CONFIDENTIAL NEW PATIENT INFORMATION

NAME: DATE: AGE: D.O.B: SEX: M / F

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: WORK PHONE: MOBILE PHONE:

MARITIAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Partner

OCCUPATION: EMPLOYER: HRS/WEEK:

SPOUSE'S NAME: OCCUPATION: EMPLOYER:

NAMES and AGES OF CHILDREN:

EMERGENCY CONTACT: RELATIONSHIP: PHONE:

EMAIL ADDRESS: OK to email for office & appt. correspondences? □ Yes □ No

WHOM MAY WE THANK FOR **REFFERING** YOU TO OUR OFFICE?:

CURRENT HEALTH CONDITION

Main Reason(s) for consulting our office: □ Wellness Care Only □ Health Concerns

	Have you had this Before?	Injury Related?
1	□ Yes □ No	□ Yes □ No
2	□ Yes □ No	□ Yes □ No
3	□ Yes □ No	□ Yes □ No

When did this start?:

How did this begin?:

How are your symptoms changing: □ Getting Better □ Not Changing □ Getting Worse

What makes it Better? □ Nothing □ Lying Down □ Walking □ Standing □ Sitting □ Movement □ Exercise □ Inactivity/Rest □ Other

What makes it Worse? □ Nothing □ Lying Down □ Walking □ Standing □ Sitting □ Movement □ Exercise □ Inactivity/Rest □ Other

Describe the current symptom(s): □ Sharp/Stabbing □ Throbbing □ Aches □ Dull □ Soreness □ Weakness □ Numbness □ Shooting □ Gripping □ Burning □ Tingling □ Other

Does the pain Radiate to another area? □ Yes □ No If 'Yes', please describe:

Are there any Associated Signs or Symptoms with the pain? (Ex: Chest Pain, Bladder/Bowel Problems…) □ Yes □ No
If 'Yes', please describe:

How often are the symptoms present? □ Constantly (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (0-25%)

Please indicate the intensity of the symptoms: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

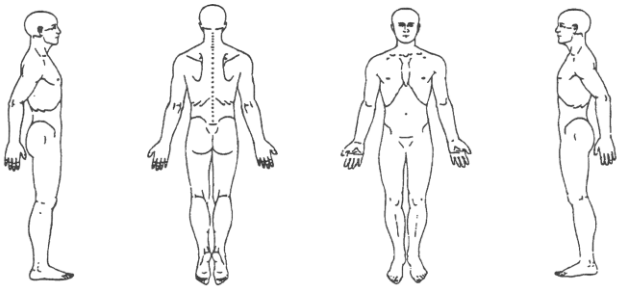
Are these concerns interfering with your daily activities? (Ex: work, sleep, leisure, etc…)

Please describe:

Have you seen anyone else for this condition? □ No One □ Other Chiropractor □ Medical Doctor □ Physical Therapist □ Other

What tests were performed?
□ X-rays *date:*_____
□ MRI *date:*_____
□ CT Scan *date:*_____
□ Other *date:*_____

Indicate the area you have pain or symptoms:



Current Medications:

Current Supplements:

Present Weight: Present Height:

CONFIDENTIAL NEW PATIENT INFORMATION

PAST HEALTH HISTORY

Have you ever had Chiropractic Care before? □ Yes □ No
Date of Last Adjustment? _____
Doctor's Name and Location? _____
Did the Doctor take Spinal X-rays? □ Yes □ No
Did you have a thorough examination? □ Yes □ No
Results of care: □ Excellent □ Good □ Average □ Did Not Help □ Got Worse

For Women:

Are you pregnant?	□ Yes	□ No
Are you nursing?	□ Yes	□ No
Are you using birth control?	□ Yes	□ No
Method? _____		
Do you experience painful periods?	□ Yes	□ No
Do you have irregular cycles?	□ Yes	□ No
Have you ever had a miscarriage?	□ Yes	□ No
Do you have breast implants?	□ Yes	□ No
Date of last menstrual cycle? _____		

Previous Accidents / Injuries / Fractures (especially those relating to your current condition):

1. Type:	Date:
2. Type:	Date:
3. Type:	Date:
4. Type:	Date:
5. Type:	Date:

Previous Surgeries / Operations (all types):

1. Type:	Date:
2. Type:	Date:
3. Type:	Date:

Please check the appropriate boxes if you have ever had a listed condition in the PAST or PRESENT.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Neck Pain (723.1)	☐	☐	Chronic Cough (786.2)	☐	☐	Prostate Problems (601.9)
☐	☐	Shoulder Pain (719.41)	☐	☐	Chronic Sinusitis (473.9)	☐	☐	Blood Disorder (790.6)
☐	☐	Pain in Upper Arm/Elbow (719.42)	☐	☐	General Fatigue (780.7)	☐	☐	Emphysema/Lung Problems (492.8)
☐	☐	Hand Pain [R / L] (719.44)	☐	☐	Breast Soreness/Lumps (611.72)	☐	☐	Arthritis (716.9)
☐	☐	Wrist Pain [R / L] (719.43	☐	☐	Endometreosis (617.9)	☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Upper Back Pain (724.1)	☐	☐	PMS (625.4)	☐	☐	Diabetes (250.0)
☐	☐	Low Back Pain (724.2)	☐	☐	Loss of Bladder Control (788.30)	☐	☐	Epilepsy (349.58)
☐	☐	Herniated Disc	☐	☐	Painful Urination (788.41)	☐	☐	Ulcer (556.9)
☐	☐	Pain in Upper Leg/Knee (719.5)	☐	☐	Frequent Urination (788.41	☐	☐	Liver Problems (573.9)
☐	☐	Pain in Low Leg/Knee (729.5)	☐	☐	Abdominal Pain (789.0)	☐	☐	Gallbladder Problems (575.9)
☐	☐	Pain in Ankle/Foot (719.47)	☐	☐	Constipation/Irregular Bowel (564.0)	☐	☐	Kidney Stones/Problems (592.0)
☐	☐	Jaw Pain (526.9)	☐	☐	Difficulty Swallowing (787.2)	☐	☐	Hepatitis (573.3)
☐	☐	Swelling/Stiffness of Joints(s)	☐	☐	Heartburn/Indigestion (787.1)	☐	☐	Bladder Infection (595.9)
☐	☐	Fainting (780.2)	☐	☐	Dermatitis/Eczema/Rash (692.9)	☐	☐	Colitis (558.9)
☐	☐	Visual Disturbances (368.9)	☐	☐	Depression (311)	☐	☐	Irritable Bowel (564.1)
☐	☐	Convulsions/Seizures (780.3)	☐	☐	Aortic Aneurysm (441.5)	☐	☐	HIV/AIDS (042)
☐	☐	Loss of Balance	☐	☐	High Blood Pressure (401.9)	☐	☐	Systemic Lupus
☐	☐	Dizziness (780.4)	☐	☐	High Cholesterol	☐	☐	Appendicitis
☐	☐	Headache (784.0)	☐	☐	Angina (413.9)	☐	☐	Sleeping Disorder
☐	☐	Muscular Incoordination (781.3)	☐	☐	Heart Attack (410.9)	☐	☐	Mental Disorder
☐	☐	Tinnitus/Ear Noises (388.30)	☐	☐	Stroke (436)	☐	☐	Pace Maker
☐	☐	Rapid Heart Beat (785.0)	☐	☐	Asthma (493.9)	☐	☐	Congential Disease
☐	☐	Chest Pains (786.5)	☐	☐	Cancer (199.1) _____	☐	☐	Circulatory Problems
☐	☐	Excessive Thirst (783.5)	☐	☐	Tumor (229.9)	☐	☐	Thyroid Problems
☐	☐	Loss of Appetite (783.0)	☐	☐	Tuberculosis	☐	☐	Allergies: _____
☐	☐	Anorexia (307.1)	☐	☐	Pneumonia	☐	☐	Multiple Sclerosis
☐	☐	Abnormal Weight Gain/Loss (783.1/2)				☐	☐	Other: _____
☐	☐	Bulimia	☐	☐	Venereal Disease	☐	☐	Other: _____

FAMILY HISTORY

Please check if Family members have/had any of the following:

☐ Cancer	☐ Lung Problems	☐ Lupus	Additional Comments:
☐ Rheumatiod Arthritis	☐ Epilepsy	☐ High Blood Pressure	
☐ Diabetes	☐ Chronic Back Problems	☐ Heart Disease	
☐ Heart Problems	☐ Chronic Headaches	☐ Other: _____	

SOCIAL HISTORY

Describe your stress levels (1=none, 10=extreme): Occupational: _____ Personal: _____

	Never	Occasionally	Moderately	Excessive	Additional Comments:
Alcohol	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Sodas	☐	☐	☐	☐	

	Poor	Good	Excellent	Additional Comments:
Diet	☐	☐	☐	
Exercise	☐	☐	☐	
Sleep	☐	☐	☐	
Posture	☐	☐	☐	
General Health	☐	☐	☐	

GOALS FOR MY CARE:

Please describe your health goals:

PATIENT SIGNATURE:

DATE:

LAKELAND
CHIROPRACTIC

CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, you must recognize that there are risks associated with all health care procedures which you should be informed about. All practitioners who adjust the spine are required to warn patients of material risks and seek informed consent for chiropractic care.

- Chiropractic adjustments of the spine are internationally recognized as being far safer in dealing with neck and low back pain than medication and many other alternatives. -
[A Risk Assessment of Cervical Manipulation, JMPT, 1994, Magna Report, Ontario Ministry of Health, 1993]

Please read the following carefully:

1. I acknowledge there are rare risks associated with chiropractic care which include, but are not limited to, muscle strains, joint soreness, nausea and dizziness, fractures, disc injuries, strokes (or like episodes), and an exacerbation and/or aggravation of the underlying condition.
2. I acknowledge that I am aware of the potential risks. I appreciate that results are not guaranteed and that fees charged for services rendered are not subject to challenge with regard to perceived effectiveness of the procedure.
3. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care plan.
4. I hereby acknowledge my consent to chiropractic care by my primary Chiropractor at Lakeland Chiropractic or any other chiropractor working in this clinic. I understand that I may withdraw consent at any time and that it must be done in writing.

We have an “open door adjustment policy”. If you prefer to have the door closed during adjustments, please notify a staff member or the doctor during your appointment. We will be happy to accommodate your request.

_____ _____

Patient Signature
(Parent or Guardian to sign for patient under 18)

Chiropractor’s Signature

_____ _____

Patient Name [printed]

Date

220 South Business Park Drive Unit A-7 Oostburg, WI 53070 **phone** 920.564.6061 **fax** 920.564.6081
www.lakelandchiro.net **email:** lakelandchirooostburg@gmail.com

LAKELAND CHIROPRACTIC - OOSTBURG

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, inclement weather cancellations, information about care alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left by phone or with the person answering the phone. **We may also contact you by e-mail or text.** By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages by phone or with individuals at your home or place of employment.

Preferred Way of Communication (check box): ☐ **TEXT** ☐ **EMAIL** ☐ **CALL**

PHONE: _____ EMAIL: _____

You may restrict the individuals or organizations to which your health care information is released or you my revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone with access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

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LAKELAND
CHIROPRACTIC

OFFICE POLICIES

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of care that your doctor feels is best for you. Because your condition requires numerous appointments over the next few months, we have designated a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume responsibility of adherence to the appointment program as it is designed for optimum results.

If for any reason, you are unable to keep your appointment, we require that you telephone immediately to reschedule that visit. It is the patient's obligation to **make up a missed appointment within 7 days of any cancellation.** Also, this office reserves the right to charge for missed appointments and those appointments canceled without 24 hours' notice.

We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. We want to be respectful of your time, and put forth the utmost effort to run *on time*. Occasionally, unforeseen clinical circumstances may arise that cause us to run behind. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

FINANCIAL POLICY

As a courtesy to you, our office will assist you in filing your health care claim with your insurance carrier. We must have accurate and complete information at the time of service. Read your policy and know its provisions as well as its exclusions. If there are any changes in your policy or coverage, it is your responsibility to inform our office staff so we can file your claims properly.

You are personally responsible for all fees for services provided not covered by your insurance company. The insurance company has a contract with you (and/or your employer) and not with the doctor. We will verify your coverage as a courtesy to you, but this is not a guarantee of benefits.

Our practice is committed to providing the best care for our patients at a reasonable rate. We charge what is **usual and customary** for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary.

All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service.

We offer "**payment at time of service" cash discounts** for those who care to participate. This is an individual financial agreement. We ask that this confidential contract be kept between yourself and our clinic.

- Due to the nature of these discounts, **payment is legally required at the time of service.**
- Patient balances may not exceed $200 at any time.
- Returned checks and balances over 30 days may be subject to additional collection fees and interest.
- All accounts not paid within 90 days will be put through to collections.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES FOR PATIENTS.

Signature _____ **Date** _____

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