Release Chiropractic New Patient Questionnaire

Today's Date: _____

Patient Information – Please print.

Name: _____ What do you prefer to be called?: _____

☐ Male ☐ Female Date of birth: ____/____/_____ SS # _____

Street Address: _____

_____

City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Education: ☐ Non-student ☐ Part time student ☐ Full time student

Emergency Contact Name: _____ Phone: _____ Relationship: _____

How did you hear about us?: _____

Employed: ☐ No ☐ Part time ☐ Full time Occupation: _____

Employer Business Name: _____

Employer Address: _____

Street City State Zip Code

Insurance Information

☐ I will be paying for the services and/or products myself

☐ Please bill my insurance company – Please provide copy of insurance card to front desk

Health History – Please circle all that apply.

AIDS/HIV	Allergy shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Parkinson's	Polio
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V.D.	Whooping Cough	
Chronic Fatigue	High blood pressure		Fibromyalgia				

Previous surgeries and dates: _____

_____

Please list all medications you are currently taking: _____

_____

What kind of exercise do you do: _____

What supplements do you take: _____

How much do you smoke per day: _____ Drink per week: _____

Women –

How many children: _____ Date of last menstrual cycle: _____ Pregnant? Y N Nursing? Y N Taking birth control pills? Y N

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requisition from Dr. Whittemore. The information within this chart is confidential. I understand that if request release of my records, unless specifically specified in writing. Otherwise, ALL records may be made available. I understand that I have a responsibility to communicate honestly with Dr. Whittemore and notify him of any changes in my health status. Release of Records: I authorize _____ to release all health records necessary for my treatment and/or evaluation to Lee A. Whittemore D.C.

Patient's Signature: _____ Date: ____/____/_____

(OR Responsible Party's Signature if patient is a minor)

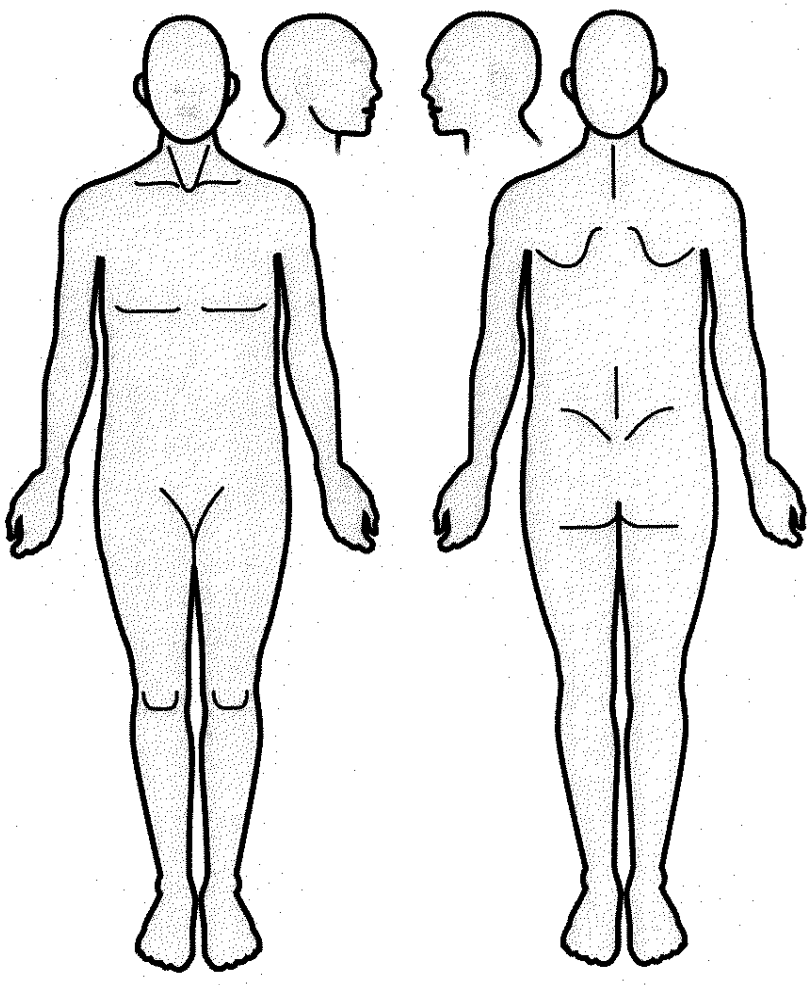
Release Chiropractic Pain Drawing - Tell Us Where It Hurts

Name: _____ Today's Date: _____

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below. **Please draw in all scars from surgeries or lacerations.**

Ache > > > > > > > >	Numbness = = = = = = = =	Pins and Needles o o o o o o o o
Burning x x x x x x x x	Stabbing / / / / / / / / /	Throbbing ~ ~ ~ ~ ~ ~ ~ ~



Symptoms:

Main complaint: _____

_____

How often does it hurt: _____

_____

When did it start: _____

Getting worse: ☐ Y ☐ N

Getting better: ☐ Y ☐ N

What activity bothers it the most:

_____

_____

Rate the pain on average:

None Worst

0 1 2 3 4 5 6 7 8 9 10

Have you seen:

☐ Other Chiropractors

☐ Physical therapists

☐ Other types of physicians

Please explain: _____

_____

_____

Any secondary complaints: _____

_____

_____

Do you currently or in the past have:
(Please mark all that apply)

	Currently	Past
Weight gain or loss	☐	☐
Unusual fatigue	☐	☐
Sleep problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Depression	☐	☐
Irritability	☐	☐
Mood swings/changes	☐	☐

	Currently	Past
Asthma	☐	☐
Eczema	☐	☐
Hay fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Gall bladder trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding trouble	☐	☐

	Currently	Past
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Shortness of breath	☐	☐
Lung or breathing problems	☐	☐
Chronic cough	☐	☐
Pneumonia	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐

Patient Name: _____

Date: _____

Do you currently or in the past have:
(Please mark all that apply)

	Currently	Past
Growing moles or lumps	☐	☐
Other skin problems	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

	Currently	Past
Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Dizziness	☐	☐
Sinus infections	☐	☐
Motion sickness	☐	☐
Dental problems	☐	☐

Date of last dental exam: _____

	Currently	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Vomiting blood	☐	☐
Bloody or black stools	☐	☐
Heartburn	☐	☐
Change in appetite	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

	Currently	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Weakness or paralysis	☐	☐
Coordination problems	☐	☐
Memory loss	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

FAMILY HISTORY: Please place an X in the appropriate square if applicable.

	Allergy	Asthma	Alcohol Abuse	Arthritis	Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or Back Disorder	Stroke	Tuberculosis	Other
Maternal Grandmother																		
Maternal Grandfather																		
Mother																		
Paternal Grandmother																		
Paternal Grandfather																		
Father																		
Brothers and Sisters																		
Spouse																		
Children																		

Are you currently experiencing or in the past have experienced: (Please mark all that apply)

	Currently	Past
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joint	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, hands, or fingers	☐	☐
Numbness or pain in the legs, feet, or toes	☐	☐

MALES ONLY: Do you have

☐ Changes in urine stream ☐ Prostate trouble Date of last prostate exam: _____

☐ Lumps in testicles ☐ Sex concerns

FEMALES ONLY: Do you have

☐ Menstrual problems ☐ Vaginal discharge ☐ Tubal infections

☐ Abnormal bleeding ☐ Sex concerns ☐ Breast lumps or pain

☐ Problems getting pregnant

Age periods began: _____ Number of pregnancies: _____

Number of miscarriages or abortions: _____ Number of Cesarean sections: _____

Date of last gynecological exam: _____ Are you currently or possibly pregnant?: _____

Patient Name: _____ Date: _____

TESTS: Please list the most recent date.

Chest X-ray _____
Tuberculosis _____
EKG _____
Tetanus Shot _____

Other X-rays (Please explain)

_____
_____
_____

HABITS:	YES	NO
Tobacco Use	☐	☐
Alcohol Consumption	☐	☐
Coffee or Tea Consumption	☐	☐
Other Drug Use	☐	☐
Exercise	☐	☐

If yes, please explain

_____
_____
_____
_____
_____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, and herbs.

_____
_____
_____
_____

ALLERGIES: Please list all known allergies.

_____
_____
_____
_____

HOSPITALIZATIONS, OPERATION, AND INJURIES: Include auto and on-the-job accidents.

Cause and Type	Year

SERIOUS ILLNESSES: List current and past illnesses not mentioned above (including cancer, diabetes, etc.)

_____
_____
_____
_____
_____

Are you presently receiving: ☐ Medical Care ☐ Chiropractic Care ☐ Other Therapy
Are your current complaints related to: ☐ Auto Accident ☐ Work-related Accident ☐ Other Accident
Are you: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Patient Name: _____ Date: _____

Release Chiropractic Patient Billing Information

I understand that all payments are due to **Release Chiropractic and Wellness Center** at the time services are rendered, except when prior arrangements are made. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Initial Consultation:
Initial consultation does not include any exams or x-rays. X-ray services are subject to separate outside fees. All fees are subject to change without notice.

New/Existing Patient Examinations:
Patient exams are conducted by the doctor to get an overall view of health status and problem areas. Examinations include a manipulation.

Medicare:
Manipulation is the only covered chiropractic service by Medicare. You may be required to pay a copay.

A charge of $25.00 will be assessed for a missed appointment. We require a 24 hour notice for cancellations.

If you or your insurance company request copies of your medical records, a $30.00 copy charge as well as $0.10 per page will be billed to you. You may try to recover this charge from your insurance company.

Any financial arrangements are to be determined prior to services rendered.

I agree to the terms above, and acknowledge that in the eent that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with Release Chiropractic and Wellness Center will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

_____
Printed Name

_____ _____
Signature of Patient or Responsible Party Date

Release Chiropractic HIPAA Acknowledgement

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____

Date of Birth: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Date: _____

By: _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By: _____
Signature of Parent/Guardian (circle one)