Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: M F
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft. in.
City:	State: Zip:	Weight: lbs.
Email:	Cell Phone: - -	Other Phone: - -
Emergency Contact:	Emergency Relation:	Emergency Phone: - -

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? Yes No

- If yes, please name them and their specialty:

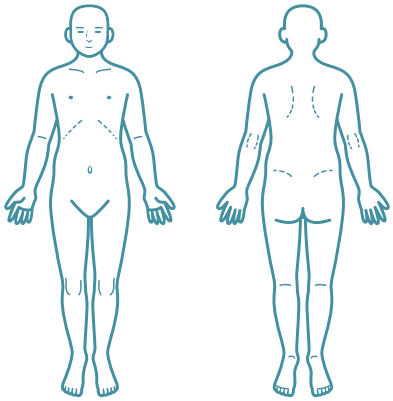
Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition



Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

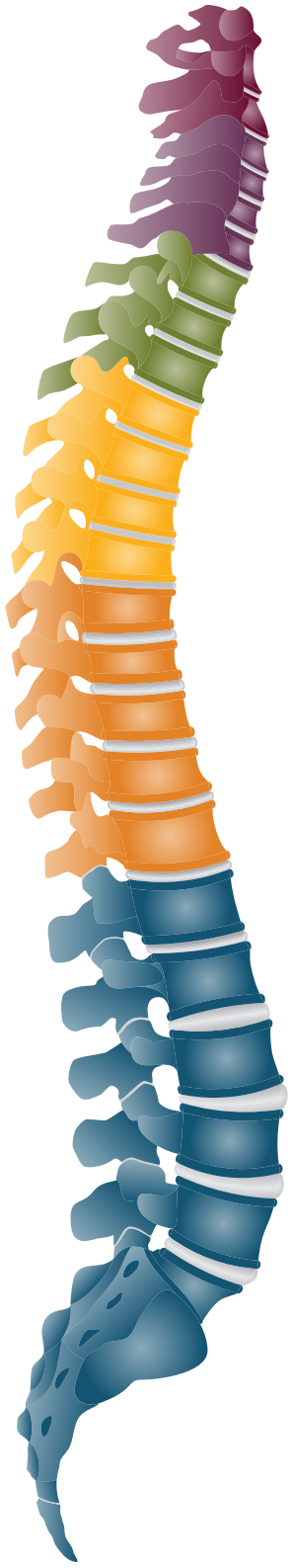
Patient Name: _____ Date: __/__/____

Dr. Sarah A. Smasal | Smasal Family Chiropractic
2900 N 117th Street, Wauwatosa, WI | 414-774-6757
caringstaff@smasalchiro.com | www.smasalchiro.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___

Consent For Use and Disclosure of Health Information

This notice describes how Smasal Family Chiropractic may use and disclose your medical information, your rights as a patient, and ways for you to get additional information on our policies.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health-related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the “NOTICE OF PRIVACY PRACTICES” binder in reception or ask for a copy at the Front desk.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative (Printed)	Personal Representative Signature	Date

Smasal
Family Chiropractic

2900 N 117th Street
Wauwatosa, WI 53222
414-774-6757
414-774-6734
www.smasalchiro.com

FINANCIAL POLICY

PATIENTS WITHOUT INSURANCE

Smasal Family Chiropractic offers our patients a "Time of Service" discount. To qualify for this discount, the patient must pay 100% of the fees for that day of service on the same day as the services are rendered. In addition, Smasal Family Chiropractic will NOT file these claims with any insurance company. If the patient has insurance and wants to take advantage of the "Time of Service" discount, they will be responsible for filing their own insurance.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain your insurance covers Chiropractic, although most policies do provide some coverage. The amount they pay varies from one policy to another. We highly recommend that you contact your insurance to verify that our office is a participating provider for your policy and what type of coverage your policy provides. This is also a good opportunity to ask if your policy requires a primary care referral or pre-authorization for services. We highly encourage patients to call and obtain coverage information prior to receiving services. Smasal Family Chiropractic is not responsible or required to obtain this information for you.

Any non-covered services rendered, deductibles, or co-pays are charged to you directly and you are personally responsible for payment.

"ON THE JOB" INJURY (Worker's Compensation)

We do not provide care for these cases.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are three options available to the PI patient:

1. If you have chosen to retain an attorney, we require that you pay cash for your care at time of service. We do not bill your attorney however we will provide you with receipts to submit to them. We will also submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will bill your standard health insurance plan, and you will be responsible for all co-pays and deductibles as they are incurred.

   You must choose one of the options presented above. Once chosen, we are unable to change it.

MEDICARE

We do accept assignments from Medicare. Medicare coverage of chiropractic care is ONLY for treatment to the spine (NOT knees, shoulder, etc.). Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, maintenance care, examinations, Insight Scans, therapies, and/or nutritional supplements. Secondary insurance may or may not pay for these non-covered services. If your secondary insurance denies coverage for ANY reason, you are responsible for payment.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for the payment of services rendered in our office may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment to your account.

I have read and understand the payment policy of Smasal Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Smasal Family Chiropractic and my insurance company. I request that Smasal Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond, deny payment or if I suspend or terminate my schedule of care as prescribed by Dr. Smasal that fees will be due and payable immediately.

By signing below I have read, understand and agree to the above financial policy.

_____ _____

PATIENT SIGNATURE *DATE*

Smasal
Family Chiropractic

2900 N 117th Street, Suite 130
Wauwatosa, WI 53222
Phone 414-774-6757
Fax 414-774-6734
www.SmasalChiro.com

Missed Appointment Policy

Thank you for trusting your chiropractic care to Smasal Family Chiropractic. When you schedule an appointment with Smasal Family Chiropractic, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than the opening of the business on the day of your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Effective May 15, 2021, any established patient who misses an appointment with no notice will be charged a **$30.00 fee**.
- Any established patient who misses an appointment with no notice a second time will be charged a **$55.00 fee**.
- If a third missed appointment with no notice should occur the patient may be dismissed from Smasal Family Chiropractic.
- Any new patient who misses their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact us, and we may be able to waive the No Show fee. You may contact Smasal Family Chiropractic 24 hours a day, 7 days a week at the number below. Should it be after regular business hours, Monday through Thursday or a weekend, you may leave a message. Our current business hours are posted on our website.

414-774-6757 **caringstaff@smasalchiro.com** **www.smasalchiro.com**

Patient Signature _____ Date _____

Patient Name Printed _____