Turning Point Chiropractic New Patient Questionnaire

Date:

Legal Name: ______________________ Sex: ☐ Male ☐ Female DOB:_____/_____/_______

Height: ________________ Weight: ________________ Marital Status: ☐ Married ☐ Single

Address: ______________________ City, State, Zip:______________________

Spouse's Name: ______________________ Number of Children & Ages: ______________________

Email: ______________________ Cell Phone: ______________________ Other#: ______________________ Home/Work?

Emergency Contact: ______________________ Emergency Relation: ________________ Emergency Phone: ______________________

Employers Name: ______________________ Occupation: ______________________

How did you hear about us? ______________________

Reason For Seeking Care

What is the purpose of your visit? ☐ Preventative Wellness ☐ Complaint ☐ Auto Accident Injury ☐ Work Injury

Main Complaint: ______________________

Health History

Please mark the conditions that apply to you. ☐ **DENIES ALL**

Past	***Current***		***Past***	***Current***		***Past***	***Current***	
☐	☐	Chronic Fatigue	☐	☐	Joint Replacement	☐	☐	Allergies
☐	☐	Tobacco Use	☐	☐	Anxiety	☐	☐	Throat Problems
☐	☐	Alcohol Use	☐	☐	Depression	☐	☐	Ear Problems
☐	☐	Cancer	☐	☐	Shortness of breath	☐	☐	Nose Problems
☐	☐	Dizziness	☐	☐	Asthma	☐	☐	Eye Problems
☐	☐	Ringing in ears	☐	☐	Diarrhea	☐	☐	Urinary Problems
☐	☐	Headaches/Migraines	☐	☐	Digestive Problems	☐	☐	Bed Wetting
☐	☐	Seizures	☐	☐	Acid Reflux	☐	☐	Prostate Problems
☐	☐	Leg/Foot Numbness	☐	☐	Constipation	☐	☐	Easy Bruising
☐	☐	Arm/Hand Numbness	☐	☐	Hot flashes	☐	☐	Poor Circulation
☐	☐	Muscle Aches	☐	☐	Hair loss	☐	☐	High Blood Pressure
☐	☐	Trouble Walking	☐	☐	Diabetes	☐	☐	Low Blood Pressure
☐	☐	Joint Stiffness	☐	☐	Menstrual Problems	☐	☐	Heart Attack
☐	☐	Osteoporosis	☐	☐	Hypothyroidism	☐	☐	Stroke
☐	☐	Rheumatoid Arthritis	☐	☐	Hyperthyroidism	☐	☐	Osteoarthritis

Other Medically Diagnosed Conditions: ______________________

Please list all surgical operations and hospitalizations:______________________

____

List Prescription & Non-Prescription drugs you take:______________________

Family Health History

Father's Side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other ______________

Mother's Side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other ______________

Is there any other family history we should know about?______________________

TPC Team Initial__________

Activities of Daily Living

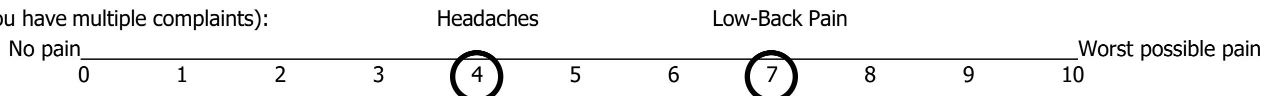
Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:			EFFECT:	
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

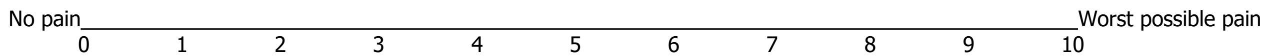
Outcome Assessment Tool

Please CIRCLE the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint.

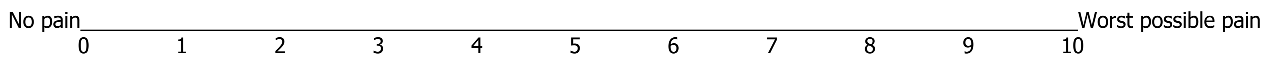
Example (if you have multiple complaints): Headaches Low-Back Pain



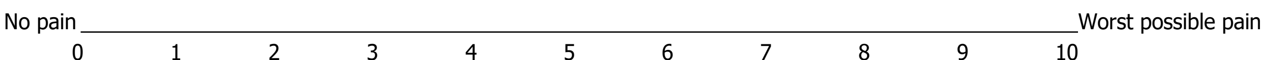
How would you rate your pain RIGHT NOW?



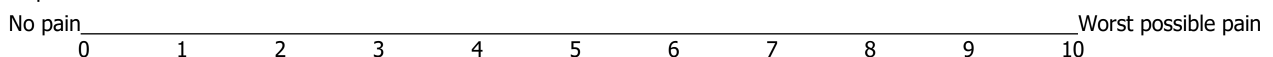
What is your typical or AVERAGE PAIN?



What is your pain level at its BEST?



What is your pain level at its WORST?



I have read the included information and certify it to be true and accurate to the best of my knowledge.

____ ______________________

Patient or Guardian Signature Date

TPC Team Initial__________

PATIENT INFORMATION (Must be completed before services can be rendered.)

Name: ____
First Middle Last

Name of Primary Insurance Carrier: ____

Is the patient the policyholder? ◯ YES ◯ NO (If you answered NO, please complete information below.)

Name of policyholder: ______________________________ Policyholder date of birth: ________________

Policyholder Address (If different than your own): ____________________________________

City, State, Zip:______________________________

Relationship to policyholder: ◯ Spouse ◯ Child

Name of Secondary Insurance Carrier: ____

Is the patient the policyholder? ◯ YES ◯ NO (If you answered NO, please complete information below.)

Name of policyholder: ______________________________ Policyholder date of birth: ________________

Relationship to policyholder: ◯ Spouse ◯ Child

<u>Insurance Policies and Fee Schedules</u>

- **Consultation—** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)**— includes one or more of the following: thermography, surface electromyography, range of motion, postural analysis, motion and/or static palpation, leg check — $30-$100
- **Chiropractic Adjustment**— the actual correction of vertebral misalignments. A sound may or may not be heard. If there is no auditory component, it does not mean that the adjustment has not taken place. — $40-$75
- **Therapeutic Exercise Instruction**— specific exercises may be prescribed to aid in your healing. — $30-$100
- **X-Rays**— Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. — $40+ per view
  - **The fee for copying your X-rays on a disc is $20.00. This fee must be paid in advance. Digital X-rays on disc will be available within 72 business hours of prepayment.**

FINANCIAL RESPONSIBILITY

Payment is **due at the time of service** for any non-covered services, deductibles or co-pays. I hereby authorize payment to be made directly to Turning Point Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Turning Point Chiropractic for any and all services I receive at this office. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Payments not made in a timely manner may incur additional interest fees that I am responsible for. Should my account be assigned to a collection agency, I understand that I am responsible for any and all associated fees set forth by the collection agency. This may be up to 50 percent of the amount I owe to Turning Point Chiropractic. This represents a long-term agreement for all occasions of service.

______________________________________ ________________
Patient or Guardian Signature Date

TPC Team Initial_________

DISCLOSURE and CONSENT for CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

____ ________________

Patient or Guardian Signature Date

Written Consent for a minor/child

Name of patient who is a minor/child ____

I authorize the doctors of Turning Point Chiropractic (TPC) and any/all TPC staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Turning Point Chiropractic.

____ ___________________

Guardian Signature and relationship to minor/child Date

TPC Team Initial_________

CONSENT TO X-RAY

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

By signing below, I consent to having the diagnostic x-rays performed, when the doctor determines is clinically necessary.

____ ________________

Patient Signature Date

FEMALE PATIENTS ONLY

I understand that if I am pregnant and have x-rays taken, which may expose my lower torso to radiation, it is possible to injure a fetus.

I am aware that ten (10) days following the onset of a menstrual period are generally considered safest for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am Pregnant.	☐ YES	☐ NO	DUE DATE:______________
I could be Pregnant.	☐ YES	☐ NO	
I am Postmenopausal.	☐ YES	☐ NO	
I have had a Hysterectomy.	☐ YES	☐ NO	
I use an IUD/Contraception.	☐ YES	☐ NO	
Other: _________________________			

My last menstrual period began on ________________________

With full understanding of the statement above, and believing that I am currently not at risk, I wish to have an x-ray examination today if requested by the doctor.

____ ________________

Patient Signature Date

CONSENT TO X-RAY A MINOR

I am a parent or legal guardian of _______________________________, who is a minor, _________ years of age. By signing below, I consent to having diagnostic x-rays performed, when the doctor determines is clinically necessary. At this time I know of no other condition which the taking of x-rays would complicate.

____ ________________

Parent/Guardian Signature Date

Turning Point Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. If you would like an additional copy, one may be requested. Once you have read this notice, please sign the last page, and return the signature to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls, text messages or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive “Detail” Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays are original records and you are therefore not entitled to them.** If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the HIPPA Compliance Office at Turning Point Chiropractic at 920.785.8802. If they are unavailable, you may make an appointment with the receptionist to see the compliance officer within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

TPC Team Initial__________

Turning Point Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I am aware that I may ask for a copy of Turning Point Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

As a patient, I understand that open adjusting bays are utilized, and with the nature of open adjusting bays I acknowledge and accept that my personal information may be heard by another person in the office. If confidentiality is required, I agree to schedule a private appointment to discuss my information.

At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ____________

Patient's Name DOB

____ ____________

Patient or Guardian Signature Date

TPC Team Initial_________