CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ______________________________ LAST NAME

______________________________ FIRST NAME MIDDLE INITIAL

Address ______________________________

City ______________ State ______ Zip: ______

Home Phone ______________________________

Cell Phone ______________________________

Email ______________________________

Sex ☐ M ☐ F Age ______ Birthday ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School ______________________________

Occupation ______________________________

Spouse's Name ______________________________

Spouse's Employer ______________________________

Spouse's Occupation ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________________________

Contact Number ______________________________

Who may we thank for referring you? ______________________________

HOW CAN WE HELP YOU?

What brings you in today? ______________________________

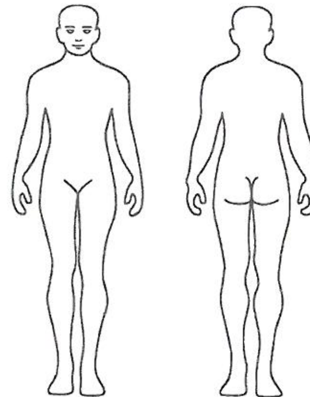
____

If you are already experiencing a symptom, what is it? ______________________________

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

0 = NO SYMPTOMS; 10 = INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other ______________

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

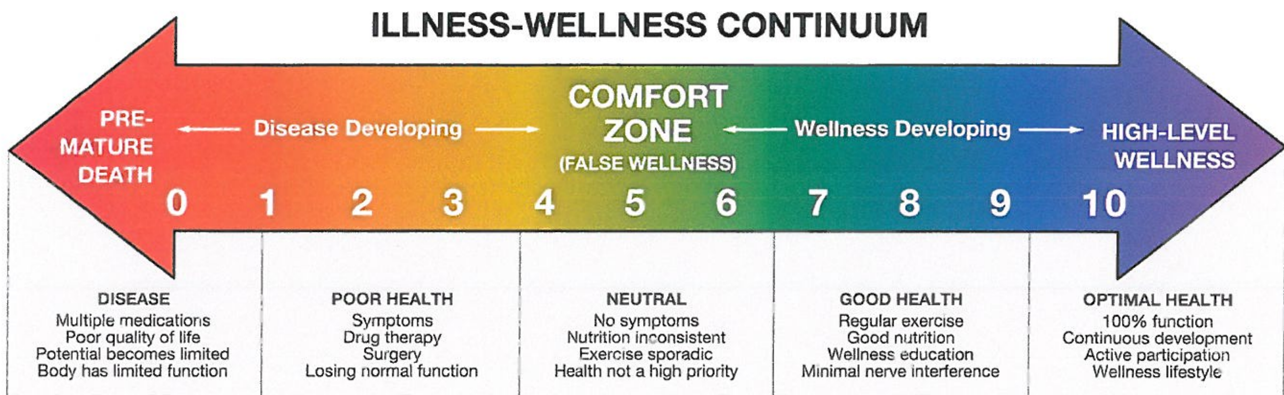
	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ________	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITTED; 10 = VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? ______

B. In what direction is your health currently headed? ______

What are your health goals?

IMMEDIATE ______

SHORT TERM ______

LONG TERM ______

CHILDREN & PREGNANCY

How many children do you have? ______

Childrens' ages? ______

Childrens' health concerns? ______

Are you currently pregnant? ☐ No ☐ Yes, I am due ______

Number of past pregnancies? ______

Health concerns regarding this pregnancy? ______

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other ______

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

______

MEDICATIONS (list)

______

SUPPLEMENTS (list)

______

ASSIGNMENT OF BENEFITS:

I ____________________________ fully understand that I am directly and fully responsible to said doctors for all bills for services rendered.

I hereby authorize my insurance company to pay directly to Wellness One of South Bergen the benefits allowable and otherwise payable to my under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay in a current manner any balance if said professional service charges are over and above this insurance payment. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain property of this office, being on the file where they may be seen at any time while a patient of this office.

____________________________ ____________________________ __________

Print Patient's Name Signature Date

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT & HEALTHCARE OPERATION

I consent to the use or disclosure of my protected health information by Wellness One of South Bergen for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Wellness One of South Bergen. I understand that diagnosis or treatment of me by the doctors of Wellness One of South Bergen may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Wellness One of South Bergen is not required to agree to the restrictions that I may request. However, If Wellness One of South Bergen agrees to a restriction that I request, the restriction is binding on Wellness One of South Bergen and its doctors.

I have the right to revoke this consent in writing, at any time, except to the extent that the doctors of Wellness One of South Bergen have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wellness One of South Bergen's Notice of Privacy Practices prior to signing this document. The Wellness One of South Bergen's Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operation of Wellness One of South Bergen. The Notice of Privacy Practices for Wellness One of South Bergen is also provided on the wall in the waiting area and on Wellness One of South Bergen's website at www.wellness1ofsb.com. This Notice of Privacy Practices also describes my rights and the Wellness One of South Bergen's duty with respect to my protected health information.

Wellness One of South Bergen reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Wellness One of South Bergen's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____________________________ ____________________________ __________

Print Patient's Name Signature Date

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WELLNESS ONE OF SOUTH BERGEN

PRIVACY POLICY

The privacy of your information is important to us. We have implemented policies that protect any personal data from improper use and alteration.

We have placed appropriate physical, electronic and managerial procures in place to safeguard any breach of privacy. Our policies comply or exceed with all Federal HIPPA regulations.

The information we collect will be used to offer superior healthcare in addition to communications and questions that will inform and enhance the healthy chiropractic lifestyle.

I consent to receive information that Wellness One of South Bergen offers me. This information could be in a written handout, electronic communication, or verbal suggestion. I am in no way obligated to follow any suggestions that are offered by the office, I understand that the suggestions are purely recommendations.

Print Name______________________ Signature_______________________ Date_____________

MISSED APPOINTMENT POLICY

Everyone here at Wellness One of South Bergen is striving to provide the best care possible. We embrace the opportunity to provide an office that is prompt, clean, effective and efficient. In order to provide the best possible results, our patient must also strive to engage their responsibility to be prompt, and thorough in completing their treatment plan.

We expect the common courtesy to arrive on time and follow through with the recommended number of visits. With the exception of emergencies, it is expected that you will keep your appointment.

If you need to reschedule your appointment, we request a 24 hour notice to do so.

In the event of a no-show for a scheduled appointment, or less than the 24 hour notice, we reserve the right to charge a $25 no show fee to your credit card on file.

Print Name______________________ Signature_______________________ Date_____________