Stillpoint Family Chiropractic, Inc.
9780 Lantern Road, Suite 230, Fishers, Indiana 46037

A Brain-Based, Family Wellness Center

On a scale of 1 - 10, please rate yourself below

Your current level of health:	*1 2 3 4 5 6 7 8 9 10*
Your current level of pain:	*1 2 3 4 5 6 7 8 9 10*
Your interest in reducing stress:	*1 2 3 4 5 6 7 8 9 10*
... getting fit:	*1 2 3 4 5 6 7 8 9 10*
... eating better:	*1 2 3 4 5 6 7 8 9 10*
... improving sleep:	*1 2 3 4 5 6 7 8 9 10*
... improving posture/mobility:	*1 2 3 4 5 6 7 8 9 10*
...improving brain function:	*1 2 3 4 5 6 7 8 9 10*
... improving quality of life:	*1 2 3 4 5 6 7 8 9 10*
... learning about wellness:	*1 2 3 4 5 6 7 8 9 10*

Personal Information

Full Name: _____ Cell phone: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Birthday: _____/_____/_____ Email: _____

☐ Yes, I want to receive appt reminders via text. *Reminder texts will come from this number **317-867-9079.** Please add this number to your contacts.* Cell Phone Carrier: _____

Place of Employment: _____ # of Years: _____

Type of Work Performed: _____

Marital Status: *Single Partnered Married Widowed Divorced*

Spouse's Name (if applicable): _____ Number of Children: _____

Please share how you were referred to our office: ○ Google ○ Facebook ○ Website ○ Friend

If referred by a friend, Please provide their name so that we can thank them _____

Emergency Contact/relationship: _____ Phone: _____

Physical Health History

Name of previous chiropractor: _____

Length of time under care: _____

What is/are your present health concern(s)? When did you first notice this issue?

Concern	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How have these issues affected your life?

_____

_____

Please list any traumas, accidents, major injuries, surgeries, or hospital stays with approximate dates:

_____

_____

_____

How would you describe your oral health (past/present)?_____

_____

(YES/NO) Have you ever been in a motor vehicle accident? _____

If yes, please describe the incident, including the date(s) : _____

_____

_____

Chemical (Nutritional) Health History:

Describe your typical meal for ...

Breakfast: _____

Lunch: _____

Dinner: _____

Approximately how much water do you drink daily? _____

Please list any supplements or prescriptions (including antibiotics) that you are currently taking, and how long you have been taking them (If you need more space, please write on the back of this page):

_____

_____

Please describe your bowel movements and urine:

	Bowels	Urine
Frequency	_____	_____
Color	_____	_____
Consistency	_____	
Difficulty Y/N	Comment:_____	

EMOTIONAL HEALTH HISTORY:

Please circle "Y" for yes, "S" for sometimes, and "N" for no.

I love myself.....	Y	S	N
I am satisfied with my life.....	Y	S	N
I enjoy my job.....	Y	S	N
I tend to have great relationships.....	Y	S	N
I am a steward of my own health and well-being.....	Y	S	N
I spend time in prayer and/or meditation on a daily basis.....	Y	S	N
I adapt well to change.....	Y	S	N
I listen to my body's messages.....	Y	S	N
I actively practice stress management.....	Y	S	N
I have a regular exercise schedule.....	Y	S	N

LIFESTYLE HEALTH HISTORY:

Describe your childhood family life:

_____

Describe your childhood activities that may have caused your body stress (involved in sports? daredevil tendencies? Violin lessons? etc.:

_____

_____

How many siblings do you have, and where are you in line? _____

Please circle all that apply to your current lifestyle:

Enjoy regular time with Nature	Extended lengths of time sitting/standing	*Labor Intensive*
Regular Detox/Cleansing	*Reading Ingredients Labels*	*Travel Often*
Community Involvement	*High-Stress Responsibilities*	Financially Stressed

BRAIN HEALTH HISTORY

Please circle all that apply:

Poor Attention	Migraines	Cold Hands/Feet
Impulsive	Headaches	Tight Muscles
Easily Distracted	Vertigo	Teeth Grinding
Disorganized	Seizures	Irritable Bowel
Depressed	Sleepwalking	Heart Palpitations
Lacking Motivation	Hot Flashes	Restless Sleep
Poor Concentration	PMS	Poor Expression of Emotions
Spaciness	Food Sensitivities	Poor Immune System
Constipation	Bed Wetting	Racing Mind
Low Pain Threshold	Eating Disorder	High Blood Pressure
Difficulty Waking	Bipolar Disorder	Accelerated Aging
Worry	Mood Swings	Anxiety
Irritable	Panic Attacks	Other: _____

FOR FEMALES ONLY

(Y/N) Do you experience menstrual pains? _____ *If yes, is the pain during your cycle or ovulation?* _____

When was your first menses? _____ Number of pregnancies? ____ (Y/N) Do you have Children? _____

If yes, what are their names and ages?

_____

Did you experience complications with any of your pregnancies or delivery? _____

_____

_____

_____

(Y/N) Have you had a cesarean birth? _____ Are you currently pregnant? Y/N Due Date:_____

(Y/N) Have you begun menopause? _____ (Y/N) *If yes, have you completed menopause?* _____

If yes, describe your transition through menopause. _____

_____

TO THE BEST OF MY KNOWLDEGE, AT PRESENT, I AM NOT PREGNANT AND I HEREBY RELEASE STILLPOINT FAMILY CHIROPRACTIC AND RADIOLOGICAL STAFF FROM ANY AND ALL RESPONSIBILITY OR LIABILITY UPON MY BEING X-RAYED FOR THE PURPOSE OF DIAGNOSTIC EVALUATION.

_____ _____

Patient signature Date

DAILY STRESSORS

Please circle all that apply:

PHYSICAL STRESSORS	CHEMICAL STRESSORS	EMOTIONAL STRESSORS
Sitting	Pollution/Allergens	Anger/Fear
Driving	GMO's	Anxiety/Worry
Lack of Sleep	Malnutrition	Depression/Grief
Unsupportive Pillow/Mattress	Artificial Sweeteners	Overwhelmed
Poor Sleep Posture	Artificial Food Coloring	Unemployed
Poor Standing Posture	Additives/Preservatives	Dislike Career
Repetitive Movements	Pesticides/Herbicides	Divorce/Break-Up
Lack of/Unbalanced Exercise	Tap Water	Relational /Family Stress
Daily Activities	Prescription Drugs	Financial Burden
Past Injuries	Vaccines	Peer Pressure
Past Surgeries	Cosmetics/Perfumes	Time Constraints
Overweight	Hygiene Products	Bullying
Dehydration	Cleaning Products	News Media
Flat Feet/Foot Support Imbalance	Aluminum Foil/Plastic Storage	Addictions
Purse/Wallet/Bookbag	Smoke	Exhaustion
Carry Kids on Hip	Caffeine	Traffic
Birth Trauma		
Mouth Guard		

PATIENT POLICY AGREEMENT

Appointments with Dr. Pennella are scheduled according to the program of care that she feels is best for you. This customized program will consist of three stages - Relief Care (relief from pain), Corrective Care (maintaining stability), and Wellness Care (prevention). Depending on where you begin, multiple adjustments will be scheduled for you in a concentrated amount of time, followed by exam(s) to monitor your progress. As you improve and your health stabilizes, you will graduate into the next stage of care. After completion of the initial program, a consultation will be scheduled to re-evaluate your stage of care, and to outline a new, customized program including health goals, accountability, and wellness education.

If you are unable to keep an appointment, we require that you inform us with 48 hours' notice. Stillpoint Family Chiropractic reserves the right to charge ***$65.00*** for missed appointments, or for those appointments cancelled without a 48 hour notice**. In order to achieve best results, every cancelled appointment must be made up within 1 week.** Following the schedule that Dr. Pennella outlines for you is of paramount importance. We ask that each patient assume the responsibility of strict adherence to the appointment schedule as it is designed for optimum results.

When entering the office on any given visit, please go directly to the front desk and sign-in. We sincerely attempt to honor all appointments at the scheduled time. If you are late, or expect to be late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call/text you in advance and advise you on the status of your appointment time. If you have any questions regarding our office policies or your appointments, please do not hesitate to ask.

At Stillpoint Family Chiropractic, we strongly support patient education. We also believe that increasing your level of health is a team effort. As Dr. Pennella is a doctor of *brain balance,* you are a doctor of *choices* - on a daily basis, you have the opportunity to decide whether your choices will contribute positively or negatively to your health. We look forward to creating a partnership with you to work towards achieving all your health goals.

I agree to make a full and honest effort towards meeting my health goals.

_____

Patient Signature

WELLNESS ORIENTATION WORKSHOP - WOW! CLASS

Attending WOW is required as part of your program of care. The purpose of requiring all new patients to attend is to encourage and enlighten our patient's understanding about the connection between the body's health, a well-balanced nervous system, and what YOU can do to achieve brain balance outside the office.

We encourage everyone to bring a guest to this workshop for personal support. We also encourage you to talk about your health experiences in this office! Sharing your story in person or on social media often results in introducing chiropractic and SFC to many in need who may not have considered it before. You are always welcome to bring anyone to a WOW class in the future as a first step in their journey towards learning about wellness and brain-based care; check with the front desk for scheduling.

I will attend a WOW class hosted by Stillpoint Family Chiropractic.

_____

Patient Signature

FINANCIAL POLICY

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are expected at the time of service, or at the end of each week. Patient balances are not to exceed $200 at any time. Returned checks and balances over 30 days may be subject to additional fees and interest charges of 1.5% per month, as well as attorney fees and any court costs related to the collection of these fees.

In terms of insurance, this office is recognized as an "out-of-network" office; we do not participate in any network. This does not mean that your insurance does not cover services rendered in this office, but that coverage is based on Out-Of-Network benefits. It is the responsibility of the patient to contact their insurance company to determine their benefits and eligibility.

Excluding all Medicare patients, Stillpoint Family Chiropractic is not responsible for the billing of services to insurance companies. Upon request of the patient, Super-Bills (patient billing) will be printed listing all services and payments made. The responsibility of sending this super-bill to the insurance company for the purpose of billing relies on the patient. Super-bills may be requested at any time.

For patients who comply with Dr. Pennella's program of care outlined on page 5, payment plans will be offered for financial assistance.

I agree to pay Stillpoint Family Chiropractic, Inc. for services rendered by using one of the following payment methods (please place a ✓ by one of the following):

☐ PRIVATE PAY (payment is made by cash, check or credit card)

- Payment is made in full at the time of service unless other arrangements have been agreed upon with Dr. Pennella.
- Payment plans; see office manager.

☐ MEDICARE (65 years of age and/or enrolled in Medicare; beginning 10/01/2009, the patient will pay Medicare rates at the time of service, and be reimbursed directly by Medicare after the deductable has been met.

- Stillpoint agrees to complete and file all usual and customary medical claims.
- Patient agrees to pay any amount determined by Medicare to be the patient's responsibility.

☐ PERSONAL INJURY (automobile or other liability injury)

- Patient must provide Stillpoint Family Chiropractic with information on the accident and insurance carrier of the faulty party.
- Alternate payment information must be submitted for coverage through MedPay Clause of patient's automobile insurance, or patient's health insurance, or both.
- PATIENT IS RESPONSIBLE FOR PAYMENT IN FULL, REGARDLESS OF COVERAGE THROUGH ANY OF THE METHODS ABOVE.
- Patient is required to pay for services until Med Pay or faulty party payment is confirmed, at which time payments will be credited to the patient.

_____ _____

Patient signature Date