NEW PATIENT INFORMATION

Please print clearly and complete all questions

Name:	Date:
Address:	City/State/ZIP:
Home Phone:	Work Phone:
Cell:	E-Mail:
Occupation:	❑Full time ❑Part time ❑Retired ❑Unemployed
Employer:	Is it okay to contact you at work? ❑Yes ❑No
Who may we thank for referring you?	
Birth Date:	Age: Sex: ❑Male ❑Female ❑:
Marital Status: ❑Single ❑Married ❑Separated/Divorced ❑Widowed Spouse's Name: Number of children / age(s): /	Number of grandchildren / age(s): /
Is there any possibility you may be pregnant? ❑Yes ❑No ❑Not sure	
Emergency Contact Name and Phone Number:	
What is your most important current goal?	
Favorite Hobbies or Interests:	
Method of Payment for First Visit: ❑Cash ❑Check ❑Credit Card ❑CareCredit ❑Gift	

Date of Last Chiropractic Adjustment: _____

When was your most recent spinal check up? ❑ Never ❑ 6 months or less ❑ 6 to 12 months ❑ 12 months or longer

Current health concerns/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Have you had same or similar problem(s) before? ❑Yes ❑No If yes, for how long?_____

Is this the result of an auto or work injury? ❑Yes ❑No If yes, when?_____

Do you have an immediate relative with similar problems? ❑Yes ❑No If yes, who?_____

Other doctors you have seen for this problem:_____

Surgeries you have had:_____

Have you ever been diagnosed with: Cancer?❑Yes(type?_____) ❑No

Heart Disease?❑Yes ❑No Stroke?❑Yes ❑No

Rate your level of physical activity: ❑High ❑Medium ❑Low Please describe:_____

_____

Rate your Stress Level: *(low)* 1 2 3 4 5 6 7 8 9 10 *(high)*

The above information is true and accurate to the best of my knowledge. I understand that the doctor will not perform a spinal adjustment or manipulation until a thorough review of medical history and spinal examination has been administered. I authorize Network Chiropractic Wellness Center to render necessary services to me and understand that I am responsible for all charges incurred.

Patient or Guardian Signature: Date:

CONTINUE ON BACK ...

Physical Stresses

❏ Auto accidents _____

❏ Falls/broken bones/ sprains _____

❏ Spinal injuries/epidural _____

❏ X-rays/CT/MRI Scans _____

❏ Repetitive postural stress - sitting/standing/computer work _____

❏ Physical abuse/violation/assault/attack _____

❏ Extensive dental work/braces/extractions _____

❏ Allergies_____

❏ Dizziness/earaches or ringing_____

Chemical Stresses

Past/Present Medications (Blood Pressure, Pain, Anti-Depressants, Hormonal, Ritalin, Antibiotics, etc)

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ Birth Control ❏ Flu shot ❏ Childhood or other vaccines/travel ❏ Adverse reactions to vaccinations

❏ Substance Abuse: _____ ❏ Past ❏ Present ❏ AA ❏ NA ❏ Other:_____

Do you regularly use?:

❏ Alcohol ❏ Tobacco ❏ Caffeine ❏ Marijuana ❏ LSD ❏ Psychedelics ❏ Cocaine ❏ Ecstasy ❏ Other:_____

❏ Fast food/processed food ❏ Artificial sweeteners/diet sodas/food additives

❏ Occupational exposure to chemicals/fumes

❏ Other _____

Mental/Emotional Stresses

❏ Childhood stress ❏ Family stress ❏ Loss of loved ones ❏ School stress ❏ Post-partum depression

❏ Mental/emotional/sexual abuse ❏ Stress of moving home/family/school ❏ Stress of being ill/pain/surgery

❏ Lack job satisfaction/success ❏ Relationship/love/intimacy issues ❏ Separation/ divorce (self or parents)

❏ Watching TV _____ hr/week ❏ Internet ___ hr/day ❏ Other emotional situations _____

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wellness center

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Patient Privacy

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Network Chiropractic Wellness Center (NCWC) will not use or disclose protected health information without a valid authorization form, except as permitted or required by the HIPAA rule. When NCWC obtains or receives a valid authorization form for use or disclosure of protected health information, such use or disclosure will be restricted to that which is the minimum necessary to accomplish the purpose described in the authorization form.

Each authorization form has to be specific to the release under consideration. The specific requirements for authorizations are outlined below.

1. Return all authorizations known to be defective to the party requesting the information with an explanation of why the requested information is not being disclosed, or
2. Have the patient review the defective authorization and have the patient read and sign a new authorization form before releasing the health information.
3. A description of each purpose of the requested use or disclosure. The statement, "at the request of the individual," is a sufficient description of the purpose when an individual does not desire to make an explanation.
4. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
5. Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.

The authorization form must contain statements adequate to place the individual on notice of all of the following:

- The individual's right to revoke the authorization in writing; and

- The potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by this regulation.

The covered entity must provide the individual with a copy of the signed authorization.

A valid authorization may also contain elements or information in addition to these required elements, provided that such additional information is not inconsistent with the required elements stated above.

If the individual refuses to sign the authorization form, the covered entity cannot condition treatment on failure to obtain such authorization

A covered entity may not use or disclose protected health information to a requesting party if the authorization is defective. A defective authorization is one that has expired, is incomplete, has been revoked, or is known to be false.

_____ _____

Print Patient Name Date

_____

Patient Signature

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INSURANCE WAIVER

Due to constant changes in health insurance policies, patient self-billing has become a cost effective way for you, the patient, to get the maximum reimbursement for your care. Furthermore, patient self-billing allows us to keep our fees low so you can get the care you need without any added cost. Our office policy is that all payment is due at the time of service.

By signing below, you acknowledge that insurance claims will not be sent to your insurance provider by our staff. However, we will provide you with a monthly statement of care which you may submit to your insurance provider. As each insurance company, policy and plan is different, we can not guarantee reimbursement and are not responsible for your policy's chiropractic coverage.

_____

Print Name

_____

Signature

_____

Date

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and **preservation of health**.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays) if needed.

Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the **removal and/or reduction of nerve interference** caused by subluxation.

Adjustments are made by chiropractors in order to **correct or reduce** spinal and extremity joint subluxations. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.

By signing below, you acknowledge that you have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments will be explained, including the risks, consequences and probable effectiveness of each, upon request. You will be advised of the possible consequences if no care is received. This office makes no guarantees concerning the results of the care and treatment that we offer.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I WILLINGLY AUTHORIZE NETWORK CHIROPRACTIC WELLNESS CENTER & BJORN BOSTROM, DC TO PROCEED WITH CHIROPRACTIC EXAMINATION AND CARE.

_____	_____
Print Patient Name	Date
_____	_____
Patient Signature	Doctor Signature

Parental Consent for Minor Patient

I give permission for the above named minor patient to be managed by the doctor, in and/or out of my presence.

_____	_____
Signature	Relationship to Patient