New Patient Intake Form

First Name _____ Middle Initial ___ Last Name_____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____-_____ Cell Phone (____) _____-_____

Email _____Date of Birth ____/____/_____ Sex: □ Male □Female
Marital Status: □Single □Married □Other Children: Yes No Ages: _____

Employment Status: □ Employed □Unemployed □FT Student □ PT Student □Other____

Emergency Contact_____Contact Name_____Relationship to Patient _____

Would you like us to verify your health insurance coverage? Yes No

How did you hear about our office? _____

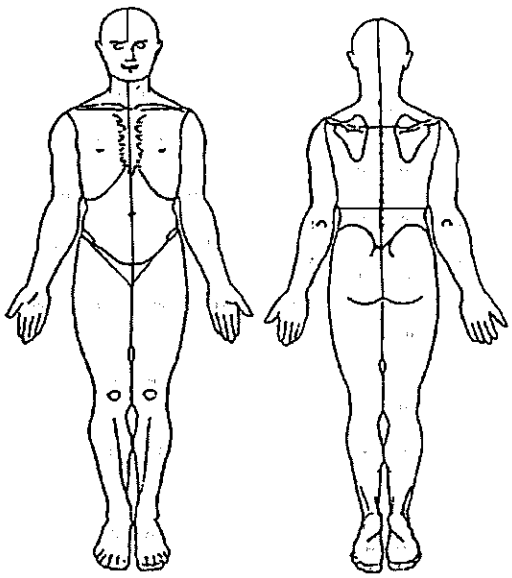
Do you have a primary complaint? _____

When and how did it begin? _____

What makes it better?_____Worse? _____

(*Women Only) Are you pregnant? Yes____ No _____Uncertain_____

Please mark on the diagram pain Is occurring.



If you are currently experiencing pain, is it: (Mark all that apply)

Sharp ____ Dull Ache ____ Burning ____
Throbbing ____ Stabbing ____ Shooting ____
Numbness ____ Tingling _____

Does the pain: Come and go□ Constant□

How often does the pain occur? Hourly___

Daily___ Weekly___ Occasionally___ N/A___

If the pain travels, where does it go?

_____

How would you rate your pain?

(0 = no pain, 10 = worst pain possible):

0 1 2 3 4 5 6 7 8 9 10

Since the onset, has the complaint? Improved___ Worsened___ Stayed the same___ N/A___

Is this keeping you from...

Working___ Exercising___ Sports/hobbies___ Driving___ Sleeping___ Family Time___

Have you ever been under chiropractic care? If so, when? _____

Following, is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Mark the following conditions that are CURRENTLY a cause of significant concern.

Current Significant MUSCULOSKELETAL Concerns:

Back/Neck Pain___ Carpal Tunnel___ Scoliosis___ Joint Pain____ Leg Pain/Sciatica___ Headaches__ Arthritis___ Swollen Join___

Current Significant CARDIOVASCULAR concerns:

Chest Pain/Angina_____ Blood Pressure Issues_____ Anemia_____ Cold Extremities____ Varicose Veins____ Heart Problems _____ Arterio/Athero Sclerosis____ Stroke_____

Current Significant GASTRO-INTESTINAL concerns:

Abnormal Appetite____ Nausea____ Constipation____ Bad Breath____ Ulcers____ Increased Thirst____ Vomiting____ Bloating/Gas____ Heartburn____ Diarrhea____ GERD/Acid Reflux____ Gall Stones____

Current Significant URINARY/REPRODCUTIVE concerns:

Kidney Infection____ Bladder Trouble____ Fibroid____ Hot Flashes____ Cramps____ Cysts____ Impotence____ Kidney Stones____ Frequent Urination____ PMS____ Excessive Menstruation____ Prostate Problems____ Painful Urination____ STD's____ Decreased Sex Drive____ Painful Menstruation____ Endometriosis____ Pregnant____ Discolored Urination____ Hemorrhoids____

Current Significant NERVOUS SYSTEM concerns:

Nervousness____ Shooting Pain____ Seizures____ Dizziness/Vertigo____ Anxiety____ Paralysis____ Loss of Balance____ Loss of Taste____ Numbness/Tingling____ Forgetfulness____ Loss of Smell____

Current Significant GENERAL concerns:

Allergies____ ADD/ADHD____ Diabetes____ Herpes Zoster/Simplex____ Fatigue____ Colic____ Autism____ Hearing____ Insomnia____ Lung Problems____ Dental____ heart disease____ Depression____ Cancer____ Chicken Pox____ Vision____

List All Current Medications (include all over the-counter, supplements, and herbs):_____ _____

_____ _____

List any accidents or traumas, when they happened, and what was injured:_____ _____

_____

List any major surgeries: Name of Primary Care Physician and Approx. Date of Last Visit:

_____ _____

Have you been treated for any conditions in the last year? Yes No If yes, please explain:

_____

Please include any additional information, concerns, or questions you would like to add:_____

The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation. I understand that all information on this form and in the file will remain confidential to myself, the doctor, and any other authorized personnel. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

Signature_____ Date_____

Whole Health Chiropractic Notice of Privacy Form

We understand that treatment about you and your health is personal. We are committed to protecting information about you. This notice briefly describes how treatment information about you may be used and disclosed.

We are required by law to:

- Make sure that treatment information that identifies with you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
- Follow the terms of the notice that is currently in effect.

We may use treatment information about you to provide you with treatment or services. We may also disclose information about you to people outside of the clinic who may be involved in your care, such as family members or others we use to provide services that are part of your care.

We may use and disclose treatment information about you so that the treatment and services you receive at the clinic may be billed to and payment may be collected from you, your insurance, or a third party.

If you are involved in a lawsuit or a dispute, we may disclose treatment information about you in response to a court or administrative order. We may also disclose treatment information to a subpoena, discovery request, or other lawful process by someone else involved in the dispute as required by federal, state, or local law.

You have the right to inspect and copy treatment information that may be used to make decisions about your care, usually, this incudes treatment billing records. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

You have the right to request an "accounting of disclosures". This is a list of the disclosures made of treatment information about you.

You have the right to request a restriction or limitation on the treatment information we use or disclose about you for treatments, payments, or health care operations. In your written request, you must tell us **(1)** what information you wanted limited; **(2)** whether you want to limit our use, disclosure, or both; **(3)** to whom you want the limits to apply. For example, disclosure to your spouse.

You have the right to request that we communicate with you about your treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

If you have any questions or concerns about your treatment regarding our policies, would like to inspect a complete copy of this document, obtain copies of your treatment information, or request disclosure of your treatment information, please contact us at **(972) 530 – 2273.**

Print Name: _____

Patient Signature: _____ Date: _____

WHOLE HEALTH CHIROPRACTIC
FINANCIAL POLICY

Thank you for choosing Whole Health Chiropractic (WHC) for your chiropractic care. We are committed to providing you with quality health care. Our financial policy is as follows:

- Please note that you will need your insurance card and proof of identity (e.g., driver's license) at your first visit. You will be responsible for providing a change of address, telephone number, and/or insurance information anytime a change occurs. We accept cash, major credit cards, and debit cards.

I. WHC has provider contracts with some insurance carriers "in-network" status.

- Insurance contracts require us to collect your co-payment at the time of service.
- Our office will assist you in receiving proper reimbursement by filling your claim promptly.
    - After your insurance company processes the claim, (in about 30 days) you will receive an Explanation of Benefits (EOB) from your insurance, which will show the "Patient ***Responsibility***" amount.
    - If there is a balance, we will provide you with a statement showing the amount due.
    - For large balances, you may contact our Billing Department to make payment arrangements using your credit/debit card.
- Individual coverage varies dramatically within our contracts and your coverage is an arrangement between you and your health plan/health insurance company.
- It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance.
- This office is not responsible for the expense of treatment not paid by your health plan/health insurance.
- With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number on your health plan/health insurance card.

II. When WHC does not have a contract with your health plan/health insurance carrier, services are "Out of Network".

- This means that you have no insurance benefits with our clinic.
- You will be responsible for the entire amount at the time services are rendered.
- As a courtesy, we can file a claim with your health plan. Should your plan pay, you will be refunded.
- Your signature on this Financial Policy will be your acknowledgement that you are aware that your Benefits will be paid as "Out of Network".

III. Motor Vehicle Accident (MVA) & Third-Party Liability

- WHC will file a claim for services provided as the result of a motor vehicle accident or third-party liability injury; however, the patient will be responsible for the entire amount.
- You will be required to complete a special Vehicle Accident Information form before you will be seen by the doctor.
- For Third Party cases, a prepayment of $95 will be required on the initial visit.

IV. Workers' Compensation

- Patients with *authorized* Workers' Compensation will not be subject to this Financial Policy.

V. No Insurance Coverage (Self Pay)

- The patient or guardian will be responsible for payment, which may include x-rays, at the time of service. There will be an additional charge for x-rays, tape, decompression, & other services.

VI. Referrals

- If your health insurance requires a referral from your primary care provider (PCP) for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If you do not have the required referral from your PCP, the visit will be rescheduled to allow time to contact your PCP and arrange for a referral.

I have read the financial policies of Whole Health Chiropractic and accept responsibility for payment of my account.

Patient Name _____ Date of Birth _____

Responsible Party Signature _____ Date _____

Whole Health Chiropractic
HIPPA Acknowledgement

Name: _____
Date of Birth: _____
Mailing Address: _____

At which of the following do we have permission to contact you?
○ Home _____
May we leave a message for you at home? □ Yes □ No
○ Cell _____
May we leave a message for you on your cell? □ Yes □ No
May we text message appointment reminders? □ Yes □ No
May we text message promotions/specials? □ Yes □ No
○Email _____
May we email appointment reminders? □ Yes □ No
May we email promotions/specials? □ Yes □ No
○ Work _____May we leave a message for you at work □ Yes□ No
○ Other _____May we leave a message for you at this number? □ Yes □ No

Other than you or your insurance company, whom may we speak to about your healthcare information?
- ○ Spouse Name/ Telephone _____
- ○ Child Name/ Telephone _____
- ○ Parent Name/ Telephone _____
- ○ Other Name/ Telephone _____

Do you have any health information that you would like to be kept confidential from any of the people you have listed? □ Yes □ No
If so, please describe: _____
_____

I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

I acknowledge I have read and signed a copy of the Privacy Notice for Whole Health Chiropractic.

Patient or Personal Representative Signature_____ Date_____

Relationship to Patient_____

Whole Health Chiropractic
~ and Spa ~

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical divide to move your joints. You may feel a "click" or "pop", such as when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebral vascular injury or stroke has been estimated at one in one million in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare ".

Other treatment options which could be considered may include the following:

Over-the-counter analgesics. The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

Medical Care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds the risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescence in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risk of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Name (Print)_____ Date_____

Patient Signature_____ Witness Signature_____

BHRT Checklist For Women

Name: _____ Date: _____

E-Mail _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	Yes	No
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		