New Patient Paperwork For Care At Northstar Chiropractic

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____ Apt#: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other Spouse's Name (if applicable): _____

Number of Children: _____ Emergency Contact Name & Phone: _____

Employer: _____ Occupation: _____

Who Can We thank For Referring You, Or How Did You Hear About Our Office? _____

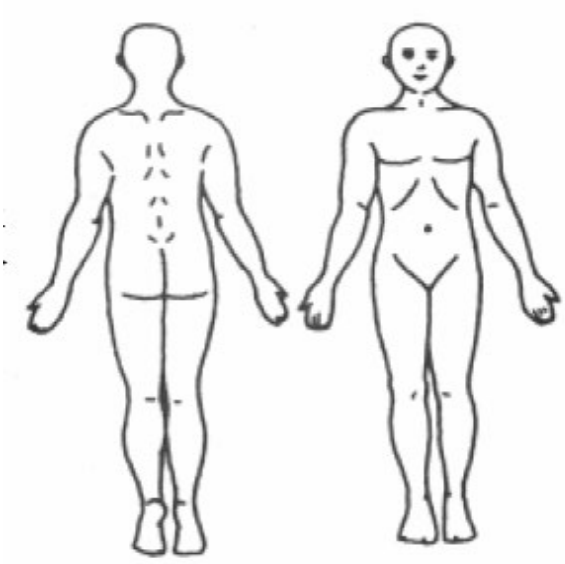
Do you have health insurance: ❑ No ❑ Yes Insurance Company: _____

ABOUT YOUR SYMPTOM(S)

Describe The Pain/Symptom(s) You Are Experiencing: _____

- Severity: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe Pain)
- How Often Do You Experience The Pain: ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Rarely
- Was The Onset Of This Pain: ☐ Gradual ☐ Sudden
- How Did This Pain Began: ☐ Unknown ☐ Trauma / Slip / Fall / Lifting Injury / Etc. ☐ Sports Injury ☐ Degenerative Process ☐ Vehicle Accident ☐ Work Injury ☐ Other:_____
- When Did This Happen/Begin? _____
- Since The Problem Began, Is It: ☐ Getting Worse ☐ Staying The Same ☐ Getting Better
- When is it the worst? ☐ AM ☐ Mid-day ☐ PM

On The Diagram, Please Mark The Corresponding Areas With The Following Letters To Describe Your Symptoms:
S = Sharp **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **T= T**ingling



<u>Additional Symptom(s)/Complaint(s) And Health Conditions</u>:

☐ Headaches / Migraines ☐ TMJ / Jaw Pain
☐ Neck Pain / Tension ☐ Dizziness / Vertigo
☐ Upper Back Pain / Tension ☐ Tinnitus / Ringing In Ears
☐ Mid Back Pain / Tension ☐ Sciatica
☐ Low Back Pain / Tension ☐ Scoliosis
☐ SI Joint Pain ☐ Herniated / Degenerated Discs
☐ Numbness / Tingling In Arms, Hands, and/or Fingers
☐ Numbness / Tingling In Legs, Feet, and/or Toes
☐ Osteoporosis / Osteopenia ☐ Rheumatoid / Osteoarthritis
☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Fibromyalgia

Patient Name: _____ **Date:** _____

ADDITIONAL HEALTH INFORMATION:

What Relieves Your Symptoms(Check All That Apply): ☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Medication ☐ Chiropractic Care ☐ Physical Therapy ☐ Other:_____

What Aggravates Your Symptoms(Check All That Apply): ☐ Bending/Turning/Twisting Motions ☐ Lifting/Carrying Objects ☐ Working ☐ Household Tasks/Chores ☐ Computer/Desk Work ☐ Sports/Recreational Activities ☐ Sleeping ☐ Getting In/Out Of Bed ☐ Sitting ☐ Sitting to Standing Motion ☐ Driving ☐ Walking ☐ Running ☐ Other: _____

Have You Seen Other Doctors/Providers For This Pain: ☐ No ☐ Yes If Yes, When: _____ For How Long: _____ By Whom? _____ Type of Treatment? _____ Was This? ☐ Favorable ☐ Unfavorable

Have You Ever Sustained Any Significant Injuries To The Spine (Whiplash, Concussions, Bad Falls, Sports Injuries, Etc.)? ❑ No ❑ Yes If Yes, What Happened: _____ When: _____

Have You Ever Been In An Auto Accident? ❑ No ❑ Yes If Yes, Date Of Last Accident: _____ Approximate Speed Of The Collision? _____ Type Of Impact: Front Impact / Side Impact / Rear Impact Was Treatment Received? ❑ No ❑ Yes If Yes, What: _____

Have You Ever Had Spine, Hip, Knee Or Ankle/Foot Surgeries: ❑ No ❑ Yes If yes, please list: _____

Does Anyone Else In Your Family Suffer From These Same Conditions? ❑ No ❑ Yes If yes, whom?: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Daughter(s) ☐ Son(s)

How Often Do You Consume:

Alcoholic Beverages: ❑ Daily ❑ Occasionally ❑ Never

Tobacco Products: ❑ Daily ❑ Occasionally ❑ Never

Please List All Medications And/Or Supplements You Currently Take: _____

_____

_____

<u>Women Only</u>:

- ☐ **To the best of my knowledge, I am not currently pregnant.**
- ☐ **I am, or may currently be, pregnant**

Patient Name: _____ **Date:** _____

RELEASE OF INFORMATION:

In accordance with all HIPPA guidelines regarding privacy of patient information and medical records, I understand that my medical information will not be released to anyone without prior written consent. The information listed on these forms are accurate to the best of my knowledge. I authorize utilization of this application or copies thereof for the purpose of processing insurance and medical claims, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability for all uncovered services.

Do you wish to release medical records to any friends or family members? ❑ No ❑ Yes If Yes, Who: _____

Patient/Guardian (If Under 18) Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY:

I hereby agree to pay all copays, coinsurance amounts, and fees for self-pay procedures/treatments as services are provided. I authorize Northstar Chiropractic to bill my insurance for services provided, and assign all payments of authorized benefits to Northstar Chiropractic. I understand that I am responsible for and may be billed for deductible and coinsurance amounts as response is received from my insurance company. If I am unable to promptly pay the amount due within 10 days of receipt of the statement, I agree to contact Northstar Chiropractic to make suitable payment arrangements. I understand that if my insurance does not cover or approve payment for services provided by Northstar Chiropractic, that I am financially responsible for and agree to pay all charges for services provided.

Patient/Guardian (If Under 18) Signature: _____ Date: _____

INFORMED CONSENT REGARDING: Chiropractic Exams, Adjustments, Therapeutic Procedures, and X-Rays

Chiropractic care, like all forms of health care, may hold certain risks. Chiropractic treatments are shown to be very safe and effective, and risks are most often minimal, such as muscle soreness following treatments. More significant health risks such as fractures, stroke, muscle contusion, etc. are extremely rare. I understand that there are also risks with exposure to x-rays. After consideration, I do hereby consent to chiropractic treatments, and/or diagnostic x-ray examinations deemed necessary by the doctor.

Patient/Guardian (If Under 18) Signature: _____ Date: _____