Welcome to Schleusner Chiropractic Center

Patient Information

Patient Name: _____ **Gender: M / F Age:** _____ **Birth Date:** _____
(Last, First) (Mo/Day/Yr)

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address:_____ **City:** _____ **State:** _____ **Zip:** _____
(No PO Boxes)

Email: _____ **Cell #:** _____ **Home #:** _____

Employer: _____ **Occupation:** _____ **Work #:** _____

Social Security #: _____ **(Circle): Part-Time / Full Time / Retired / Not Employed / Student**

Marital Status (Circle): Single / Married / Divorced / Widowed **# of Children:** _____

Females: Last Menstrual Period: _____ **Pregnant? □ Yes □No Nursing? □ Yes □ No**

If under 18: Name of Parent, Guardian or Spouse: _____ **Age:** _____ **Birth Date:** _____

Employer: _____ **Occupation:** _____ **Soc. Sec. #:** _____

Cell #: _____ **Home #:** _____ **Work #:** _____

Who may we thank for referring you? _____

Have you had previous chiropractic care? Y / N By whom? _____

Were you referred to a certain doctor in this office? □Yes □No Who? _____

Insurance card / driver's license copied by office staff? Y / N

Health Concerns: Please list your top health concerns/complaints in order of priority with **pain level 0 (no pain) to 10 (severe pain)**

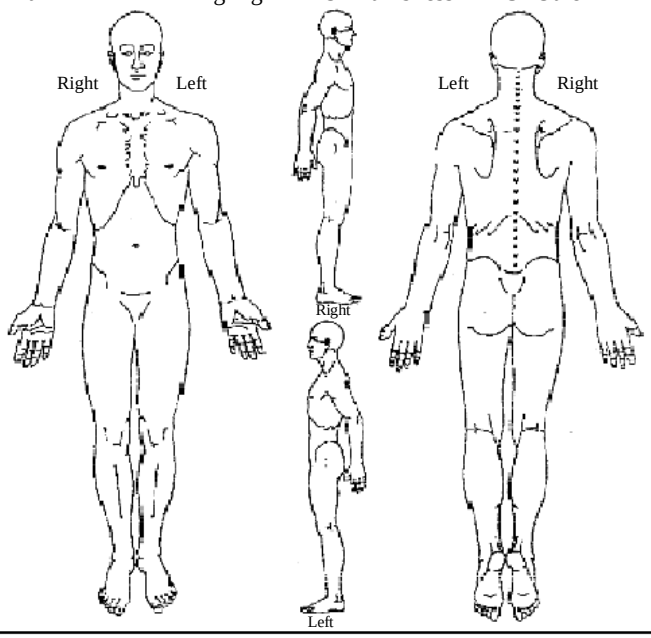
1._____ Duration- (How Long/ Date): _____
(*Circle one*) (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

2._____ Duration- (How Long/ Date): _____
(*Circle one*) (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

3._____ Duration- (How Long/ Date): _____
(*Circle one*) (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Please mark on the diagram the following symbols as they relate to your symptoms: (use these as key)

SS=Spasms **ST**=Stiffness **SH**=Shooting Pain **DP**=Dull Pain
P=Pain **TI**=Tingling **NU**=Numbness **O**=Other



Are your present problems due to an injury? Y / N
❑Auto Accident ❑Work

Was the accident reported? Y / N
❑Auto Carrier ❑Police ❑To Employer

Have you retained an attorney? Y / N
Name and Address:_____
_____

Treatment: What type of treatment are you looking for?

❑I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

❑I am looking to resolve my symptoms and "fix the cause" of my problem.

_____ _____
Patient Signature Date

In relation to your <u>PRIMARY</u> complaint, when did you first seek treatment for this problem? _____

Has another doctor (s) treated you for this condition? Y / N Whom? ☐MD ☐DO ☐DC ☐DDS Other:_____

Name of **Primary Doctor**: _____

Treatment(s) Tried: ☐Medication ☐Surgery ☐Lifestyle Change ☐Chiropractic ☐Other:_____

Have you had any intolerance or reactions to treatments? ☐Yes ☐No Describe: _____

When did your current symptoms **<u>start</u>**? _____ How did it originally occur? _____

Does your pain move or **<u>radiate</u>**? ☐Yes ☐No Where: _____

<u>Describe</u> the problem: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other:_____

<u>What</u> makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other:_____

Recently are your symptoms? ☐Getting Worse ☐Same ☐Getting Better **<u>When</u>** is the pain worse? ☐Morning ☐Day ☐Night

How **<u>frequent</u>** is the condition? ☐Constant ☐Daily ☐Intermittent What is the **<u>duration</u>**? ☐All Day ☐Few Hours ☐Minutes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily ☐Routine ☐Recreation

Is there anything you can do to **<u>relieve</u>** the symptom? ☐Yes ☐No ☐Medication (Rx/OTC) ☐Rest ☐Exercise/ Stretch ☐Other: _____

If no, what have you tried that has not helped? ☐Medication (Rx/OTC) ☐Rest ☐Exercise/ Stretch ☐Surgery ☐Other: _____

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years

What do you believe is the **<u>cause</u>** of the problem? _____

Are there any conditions or symptoms that may be related to your major symptom? ☐Yes ☐No If yes, what? _____

Have you been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 years ☐Never

<u>Medications</u>: Please check all medications you are currently taking.

☐Pain Reliever ☐Antacids ☐Antibiotics ☐Antidepressants ☐Anti-Diabetics ☐Anti-Inflammatory ☐Blood Pressure

☐Cholesterol ☐Hormone Replacements (HRT) ☐Oral Contraceptives ☐OTC (Over the Counter) ☐Other: _____

Do you take <u>Vitamins/ Supplements or Herbs</u>? ☐Yes ☐No☐

<u>Allergies</u>: Food: ☐Dairy ☐Wheat ☐Corn ☐Soy ☐Seafood ☐Gluten ☐Peanuts ☐Fruits ☐Other:_____

Medications: ☐Penicillin ☐Sulfa Drugs ☐Iodine ☐Insulin ☐Antibiotics ☐Other: _____

Seasonal/ Other: ☐Pollen ☐Dust ☐Hay ☐Mold ☐Chemical(s) ☐Smoke ☐Animals ☐Insects ☐Other: _____

Have you had any **<u>surgical procedures</u>**? ☐Yes ☐No Any Scars? ☐Yes ☐No If Yes, where: _____

Spine: ☐Cervical ☐Thoracic ☐Lumbar **Extremities:** ☐Shoulder/Elbow/Hand/Wrist ☐R ☐L ☐Hip/Knee/Ankle/Foot ☐R ☐L

Abdominal/Chest: ☐Appendix ☐Colon ☐Gall Bladder ☐Heart ☐Lungs ☐Breast ☐Thyroid ☐Female Organs ☐Other: _____

Work Activity: ☐Heavy Labor ☐Light Labor ☐Mostly Sitting ☐Mostly Standing ☐Walking/ Moving ☐Driving

Please check all symptoms that apply: (P=Past / C=Current)

P/C	P/C	P/C	P/C	P/C
❑❑Headache	❑❑High Blood Pressure	❑❑Tingling in Feet	❑❑Facial Pain	❑❑Low Blood Pressure
❑❑Walking Problems	❑❑Eye Pain	❑❑Abdominal Pains	❑❑Sore Muscles	❑❑Blurred Vision
❑❑Nausea/Vomiting	❑❑Weak Muscles	❑❑Dizziness	❑❑Poor Appetite	❑❑Paralysis
❑❑Earache	❑❑Fullness of Bladder	❑❑Shakiness	❑❑Forgetfulness	❑❑Urination Difficulty
❑❑Sweating	❑❑Confusion	❑❑Frequent Urination	❑❑Insomnia	❑❑Sinusitis
❑❑Constipation	❑❑Fainting	❑❑Teeth Grinding	❑❑Hemorrhoids	❑❑Convulsions
❑❑Dry Mouth	❑❑Decreased Sex Drive	❑❑Irritability	❑❑Excessive Thirst	❑❑Menstrual Irregularities
❑❑Impatience	❑❑Unpleasant Taste	❑❑Elbow/Hand Pain	❑❑Fatigue	❑❑Neck Pain
❑❑Tingling in Hands	❑❑Feel Loss of Control	❑❑Sore Throat	❑❑Clammy Hands	❑❑Lump in Throat
❑❑Low Back Pain	❑❑Swallowing Pain	❑❑Hip Pain	❑❑Unsteady Voice	❑❑Knee Pain

_____ _____

Patient Signature Date

Informed Consent

- I understand that the chiropractor may use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.
- The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.
- It is not reasonable to expect any doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which s/he feels at the time to be in my best interest.
- Though infrequent, as with any health procedure, there are certain health complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular injuries, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
- Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
- As the patient, I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me or translated to me, and I have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

_____ _____

Patient Signature Date

_____ _____

Staff Translation By: Date

Consent to Treat a Minor

Permission is hereby given by me to the Chiropractic Physicians at Schleusner Chiropractic Center and whomever they designate, to administer chiropractic care to this minor. I am his/her legal guardian.

_____ _____

Guardian Signature Date

We want you to know how your **Patient Health Information** (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations, we must require that you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the **HIPAA NOTICE** that is available to you in our office before signing this consent.

1.) I understand and agree to allow Schleusner Chiropractic Center to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2.) I have the right to examine and to obtain a copy of my own health records at any time and request corrections. I may request to know what disclosures have been made and submit in writing any further restrictions on the use of my PHI. It is understood that this office is not obligated to agree to those restrictions.
3.) My written consent only needs to be obtained one time for all subsequent care given to me in this office.
4.) I may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5.) For my security and right to privacy, I understand that all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in this office. All precautions known by Schleusner Chiropractic Center have been taken to assure that my records are not readily available to those who do not need them.
6.) I have the right to file a formal complaint with their privacy official about any possible violations of these policies and procedures.
7.) If I refuse to sign this contract for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8.) I certify that all the information I have provided to all foregoing questions is true and correct, and that no attempt has been made to conceal pertinent information.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient's Signature Date

_____ _____

Spouse's or Guardian's Signature Date

Billing Information

1.) We accept as payment: cash, check, Visa, MasterCard, or Discover.
2.) We accept many insurance company plans.
3.) Waiting for your insurance company's payment is a courtesy we offer but this may be withdrawn at any time. Whatever amount the insurance company does not pay is your responsibility to pay.
4.) Insurance payments should be received by us within 30 days. The maximum courtesy time the Center extends is 45 days. If at that time your insurance company has not paid, the fees are due from you immediately.
5.) Our patients must stay current with their percentage of payment responsibility. This means the deductible and appropriate co-payments are expected each visit.
6.) Insurance carriers are billed weekly by our office.
7.) All deductibles must be paid prior to insurance submittal.
8.) This Center DOES NOT control what services or fees an insurance company will cover, as not all services are a covered benefit in all contracts. While our fees are generally considered acceptable by most companies, the percentage of reimbursement varies from company to company.
9.) If the patient discontinues care for any reason, the bill is due and payable in full immediately- regardless of any claims.
10.) This Center will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.
11.) If the patient fails to keep scheduled appointments, the patient will be discharged and all bills are due and payable immediately.
12.) A 1 ½ % service charge will be assessed on any balance 45 days past the service date and is due from the patient.
13.) A $25.00 service charge is assessed on any returned checks.
14.) Missed appointments without a courtesy call to cancel in advance will be charged $25.00. We take your health seriously and anticipate that you will also. If several appointments are not kept, you will be released from our care.
15.) As the patient, I also agree to be responsible for any collections agency fees Schleusner Chiropractic may incur on unpaid balances.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations.

_____ _____
Patient's Signature Date

Over 70% of our patients bring their **children** in to get adjusted. If you would like to have your child or spouse checked for subluxations, check the box below and they can receive a **complimentary examination** including computerized surface electromyography.

This exam is no cost and does not obligate them to receive future care.

Has your spouse complained about back, neck, shoulder pain in the last 3 years?

☐ I would like my family member checked in the next 2 weeks

We want you to know that we will do our best to assist you in improving your health.

Schleusner Chiropractic Center
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