



New Patient Entrance Forms

PLEASE FILL OUT COMPLETELY- PLEASE PRINT

PERSONAL INFORMATION

Name (First) _____ (MI) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work # _____

Date of Birth _____ Age _____ Gender Male Female Marital Status : M S W D

Social Security Number _____ Email _____ No. of Children? _____

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____

Emergency Contact _____ Relationship to Patient _____

Address _____ City _____ Phone # _____

How did you hear about our office? _____

What was said that made you want to come in? _____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? Yes No When? _____

What seemed to have caused this condition? _____

What position(s), if any, make it feel worse? _____

What position(s), if any, make it feel better? _____

Over time, is this condition: Improving Unchanged Getting Worse?

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

Average pain intensity:

Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

How often do you experience your symptoms?

① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities?

① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

In general, would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Previous Care:

Have you sought advice or treatment from other doctors or therapist for **this** condition? Yes No

Have you ever been seen by a Doctor of Chiropractic before? Yes No If so, when? _____

Who is your family medical doctor: _____ Location: _____

May we communicate our findings on you current health condition to the above providers? Yes No

REVIEW OF SYSTEMS

Have you ever suffered from: *Please check all that apply.*

- | | | | | |
|---|--|---|---|---|
| <p>Ears:</p> <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earache <input type="checkbox"/> Drainage <p>Nose:</p> <input type="checkbox"/> Chronic discharge <input type="checkbox"/> Itching <input type="checkbox"/> Hay fever <input type="checkbox"/> Chronic nosebleeds <input type="checkbox"/> Sinus pain <p>Throat:</p> <input type="checkbox"/> Bleeding <input type="checkbox"/> Dentures <input type="checkbox"/> Soreness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Thrush <input type="checkbox"/> Non-healing sores <p>Neck:</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Swollen glands <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness | <p>General:</p> <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever or chills <input type="checkbox"/> Weakness <input type="checkbox"/> Trouble sleeping <p>Skin:</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Color changes <input type="checkbox"/> Hair & nail changes <p>Head:</p> <input type="checkbox"/> Headache <input type="checkbox"/> Head injury <p>Eyes:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Blurry or double vision <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts | <p>Breasts:</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Breast Feeding <p>Respiratory:</p> <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Painful breathing <p>Cardiovascular:</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Tightness <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Swelling <input type="checkbox"/> Sudden awakening of sleep from shortness of breath | <p>Gastrointestinal:</p> <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Yellow eyes or skin <p>Urinary:</p> <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Burning or pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Change in strength <p>Vascular:</p> <input type="checkbox"/> Calf pain with walking <input type="checkbox"/> Leg cramping <p>Hematologic:</p> <input type="checkbox"/> Ease of bruising <input type="checkbox"/> Ease of bleeding | <p>Neurologic:</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor <p>Endocrine:</p> <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Thirst <p>Psychiatric:</p> <input type="checkbox"/> Nervousness <input type="checkbox"/> Stress <input type="checkbox"/> Depression <input type="checkbox"/> Memory loss |
|---|--|---|---|---|

OTHER HEALTH COMPLAINTS or CONCERNS

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Ulcers/ Colitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Alcohol/ Drug Abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Heart Surgery/ Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Shingles | |

For Women Only:

Are you pregnant? Yes No Are you Nursing? Yes No Are you taking birth control? Yes No

Experience painful periods? Yes No Have Irregular cycles? Yes No Breast Implants? Yes No

FAMILY HISTORY

Do you have a family history of any of the following:
(Check all that apply)

If so, describe: _____

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease/Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Surgery/ Pacemaker | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Breathing Problems |

MEDICARE OFFICE FEES AND FINANCIAL POLICY

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees; therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the option that you would prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to help you. If you would like a full copy of our full fee schedule, please ask and we would be happy to provide that for you.

MEDICARE DOES COVER CHIROPRACTIC CARE BUT WITH LIMITATIONS.

Medicare requires that you have a current exam. Medicare does not cover the cost of the \$50 exam. Also, not covered are any therapies or supplements offered in this office. The only service covered by Medicare is manual manipulation of the spine. Medicare will cover a certain number of manipulations per incident only, or what they deem "Medically Necessary".

It is necessary to understand that maintenance care or continual care is not covered by Medicare. Maintenance care would not be related to medical necessity and therefore would not be covered under Medicare.

Any treatment Medicare considers medically unnecessary is your financial responsibility.

Please let the front desk know if you have been in any sort of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement: My signature below signifies my understanding that I will be responsible for any charges for services that are not covered by my insurance.

Patient Signature

Date

Guardian or Spouse's Signature

Date

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

Patient Signature

Date

Guardian or Spouse's Signature

Date



1604 S 1st St Suite 290, Willmar, MN 56201 PH: 320-235-2720 FX: 320-235-2220

Acknowledgement for consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by NCRC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office.

Notice of Privacy Practices

You should review the notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy _____ Patient Initials

Requesting a Restriction on the Use of Disclosure of Your Information

- You may request a restriction on the use or disclosure of you Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Some Treatment in Open or Common Areas

Private therapy areas available upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient Signature

Date

Patient Printed Name