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.*

Ears:
☐ Decreased hearing
☐ Ringing in ears
☐ Earache
☐ Drainage

Nose:
☐ Chronic discharge
☐ Itching
☐ Hay fever
☐ Chronic nosebleeds
☐ Sinus pain

Throat:
☐ Bleeding
☐ Dentures
☐ Soreness
☐ Hoarseness
☐ Thrush
☐ Non-healing sores

Neck:
☐ Lumps
☐ Swollen glands
☐ Pain
☐ Stiffness

General:
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Weakness
☐ Trouble sleeping

Skin:
☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair & nail changes

Head:
☐ Headache
☐ Head injury

Eyes:
☐ Pain
☐ Redness
☐ Blurry or double vision
☐ Visual disturbances
☐ Glaucoma
☐ Cataracts

Breasts:
☐ Lumps
☐ Pain
☐ Discharge
☐ Breast Feeding

Respiratory:
☐ Cough
☐ Sputum
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular:
☐ Chest pain
☐ Tightness
☐ Palpitations
☐ Shortness of breath
☐ Difficulty breathing
☐ Swelling
☐ Sudden awakening of sleep from shortness of breath

Gastrointestinal:
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

Urinary:
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence
☐ Change in strength

Vascular:
☐ Calf pain with walking
☐ Leg cramping

Hematologic:
☐ Ease of bruising
☐ Ease of bleeding

Neurologic:
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Numbness
☐ Tingling
☐ Tremor

Endocrine:
☐ Heat or cold intolerance
☐ Sweating
☐ Thirst

Psychiatric:
☐ Nervousness
☐ Stress
☐ Depression
☐ Memory loss

OTHER HEALTH COMPLAINTS or CONCERNS

☐ Ulcers/ Colitis
☐ Heart Attack/Stroke
☐ Thyroid Problems
☐ Kidney Problems
☐ Hepatitis
☐ Cancer
☐ Venereal Disease
☐ Congenital Heart Defect
☐ Heart Surgery/ Pacemaker
☐ High/Low Blood Pressure
☐ Asthma
☐ Arthritis
☐ Alcohol/ Drug Abuse
☐ Diabetes
☐ Shingles
☐ Chemotherapy
☐ Anemia
☐ Rheumatic Fever
☐ HIV/ AIDS

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: ____
____

☐ Heart Disease/Stroke
☐ Congenital Heart Defect
☐ Heart Surgery/ Pacemaker
☐ Kidney Problems
☐ Cancer
☐ Thyroid Problems
☐ Hepatitis
☐ High/Low Blood Pressure
☐ Arthritis
☐ Breathing Problems

SOCIAL HISTORY

Stress level: ☐ High ☐ Moderate ☐ Low Main source of stress: ________________________

Physical Work: ☐ Heavy ☐ Moderate ☐ Light

Exercise: ☐ Heavy ☐ Moderate ☐ Light ☐None

Smoking: ☐ Never ☐ Currently ☐ Previously How long? _________ Packs/Day:_________

Alcohol: ☐ Never ☐ Occasional ☐ Weekly ☐ Daily

MEDICAL HISTORY

Please list all surgeries/hospitalizations: ☐ None Date:

Please list all accidents/falls/injuries: ☐ None Date:

Medications: ☐ None Please list name and purpose: ____

Doctor's Notes:

OFFICE FEES AND FINANCIAL POLICY

Our experience has shown that it is wise to have an understanding with our clients 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.

Insurance: We will verify all insurance and your benefits per your agreement with your carrier. If your insurance covers any or all of care, it will be posted to your account accordingly. Any charge for services NOT covered by insurance is the **patient's** responsibility and will be billed out monthly or due upon service.

Same Day Discount Policy: Any account considered a CASH account qualifies for same day discount, based on services rendered. All charges must be paid in FULL on the date of service to receive the discount. Any charges not paid on the same day will be billed at the usual service fee. The initial same day cash fee for new patients, which includes the consultation, examination, and any necessary treatment, is **$76**. Subsequent office visit charges will be **$40**.

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.

☐ I would like to receive paperless billing at email: ____

I have read and agree to the above statement.

______________________________	__________	______________________________	__________
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