New Patient Intake Form

Fahrendorf Family Chiropractic + Wellness, P.C.

3909 S. Southeastern Avenue | Sioux Falls, SD 57103
Phone: (605) 334-8000 | Fax: (605) 330-0889

PERSONAL INFORMATION:

Patient Name: _____ **Preferred Name:** _____
Address: _____ **City/State/Zip:** _____
Cell #: _____ **Home #:** _____ **Work #:** _____
Email: _____ **Social Security Number**: _____
DOB: _____ **Sex:** Male / Female **Status:** Married / Single / Other
Emergency Contact: _____ **Relationship:** _____ **Phone:** _____
How did you hear about our office? _____

EMPLOYMENT INFORMATION:

Work Status: Full-time / Part-time / Retired / Student
Occupation: _____ **Employer:** _____
Address: _____ **City/State/Zip:** _____

FILL OUT IF PATIENT IS A MINOR:

Parent/Guardian Name 1: _____ Phone: _____
Parent/Guardian Name 2: _____ Phone: _____

Have you ever had chiropractic care? ☐ Yes ☐ No
If yes, who was your doctor? _____
Were you pleased with their care? ☐ Yes ☐ No

Tobacco Use: □ Never smoked □ Current Smoker, How much? _____
□ Ex-Smoker, Quit Date_____ □ Chewing Tobacco, How much? _____

Alcohol Use: □ No, I do not drink □ Yes, I do drink How much? _____
Caffeine Use: □ No, I do not drink □ Yes, I do drink How much? _____

What is your stress level? □ High □ Medium □ Low

On average, how many hours do you sleep per night? _____

What do you do for exercise? _____
_____

What are your hobbies? _____
_____

List all prescriptions medications, over-the-counter medications, and nutritional supplements you are taking:
_____
_____

List all known medical allergies (including latex or adhesives):
_____

Patient Name: _____ **Date:** _____

1. Describe your symptoms: _____
_____
Date of onset? _____ How did your symptoms begin? _____

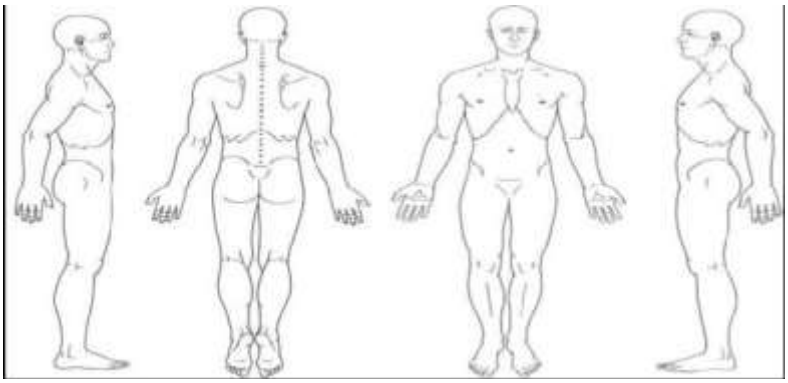
2. How often do you experience your symptoms?
☐ Constantly ☐ Frequently
☐ Intermittently

3. How are your symptoms changing?
☐ Getting Better ☐ Not Changing ☐ Getting Worse

4. What describes the nature of your symptoms?
☐ Sharp ☐ Dull Ache ☐ Numb
☐ Shooting ☐ Burning ☐ Tingling

5. Do you have numbness, tingling, or other symptoms in other areas associated with this? If so, please describe where.
_____
_____
_____

> Indicate location of symptoms <



6. Please indicate your pain intensity:

At its **best**: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **unbearable pain**
At its **worst**: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **unbearable pain**

7. What makes your symptoms worse? _____
Symptoms are worse at what time of day? _____

8. What makes your symptoms better? _____

9. Who have you seen for your symptoms? (Date seen) _____
☐ No One ☐ Medical Doctor ☐ Other Chiropractor ☐ Physical Therapist ☐ Other _____

10. Have you had similar symptoms in the past? ☐ No ☐ Yes (when?) _____

11. Any history of trauma/injury? (motor vehicle accidents, falls, sports injuries, etc.) ☐ No ☐ Yes
If so, please describe and provide date of injury: _____

12. List surgical procedures and times you have been have been hospitalized:
_____

13. Please indicate any personal history with the following conditions:
☐ Heart Disease ☐ Respiratory ☐ Diabetes ☐ Stroke ☐ Cancer ☐ Urinary (including kidneys)
☐ Digestive ☐ Depression ☐ Anxiety ☐ Arthritis ☐ Headaches ☐ Other: _____
☐ Sports Injury ☐ Fractures ☐ Dislocations
If yes to any of the above, please describe:
_____

14. Please indicate any family members with the following conditions:
☐ Arthritis ☐ Respiratory ☐ Indigestion ☐ Stroke ☐ Urinary (including kidneys) ☐ Cancer
☐ Diabetes ☐ Depression ☐ Anxiety ☐ Headaches ☐ High Cholesterol ☐ Genetic Diseases
☐ Heart Disease ☐ High Blood Pressure ☐ Other: _____
If yes to any of the above, please describe:
_____

Patient Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____ _____ _____

Patient Name (Print) **Patient/Guardian Signature** **Date**

FINANCIAL POLICY
Insurance Authorization for Release of Medical Information and Payment

*Payment options if I have **no insurance**: cash, check, or credit card on the day treatment is rendered.
*Payment options if I have **insurance**: cash, check or credit card.

I understand it is my responsibility to provide my insurance information in a timely manner, and if I fail to do so, it is my responsibility to pay for my treatment if my insurance denies my claim due to timely filing.

I agree to pay my insurance **copay** at the time of visit, or I understand there will be a $5 billing charge if copay is not paid the day treatment is rendered.

I will be responsible for any **deductible/coinsurance** amounts due and will remit payment within 30 days of receiving my statement or the account will be past due.

I understand that a **finance charge** will be imposed on any charges not paid within 30 days. The finance charge will be 1.5% per month (18% annually). The finance charge on my account is computed by applying the periodic rate (1.5%) to the "overdue balance" on my account. The "overdue balance" of my account is calculated by taking the balance owed thirty days ago, and then subtracting any payments or credits applied to the account during that time.

I understand that I can choose to sign a credit card authorization to have any outstanding balances charged to my credit card at the end of the month.
*Returned check fee: $30
*I understand that past due accounts may be sent to a collection agency if not paid within 90 days, and I am responsible for any collection/court fees incurred.

***Workers compensation**: I agree that I have filled out the necessary paperwork with my employer and have authorization/approval to see Dr. Eric Fahrendorf for treatment of this injury. If my claim is denied, I agree that I am responsible for payment in full for the treatment rendered.
***Personal injury/Auto Accidents**: I agree that I am responsible for all charges for the treatment rendered by Dr. Eric Fahrendorf. I will notify Fahrendorf Family Chiropractic + Wellness, P.C. of any necessary insurance information, including claim numbers and attorney information if applicable. If necessary, I will allow Fahrendorf Family Chiropractic + Wellness, P.C. to bill my health insurance for the charges incurred.
*By executing this agreement, I am agreeing to pay for all services that are received.

Signature: _____ Date: _____

Informed Consent for Examination and Treatment

This document explains some potential risks associated with chiropractic care. Please read this information carefully and let our staff know if you have questions.

The doctors and staff of Fahrendorf Family Chiropractic + Wellness, P.C. will do everything to assist you with your health or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem.

While chiropractic care is remarkably safe, there are some associated risks. We feel that you need to be fully informed about these risks before consenting to treatment.

Soreness – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please tell your doctor if you experience this.
Soft Tissue Injury – Rarely, chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.
Rib Injury – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize such risk.
Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor.
Stroke – Stroke is the most serious complication of chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of stroke is one in five million neck adjustments.
Other Complications – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctors and staff of Fahrendorf Family Chiropractic + Wellness, P.C. (FFCW) to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedure(s).

Patient's Name (Print)	**Date**
Signature	**Signature of Parent/Guardian**