GENESIS
CHIROPRACTIC

Genesis Chiropractic
1024 60th Street, Suite 1
Kenosha, Wisconsin 53140

Is this visit due to an auto or workman's comp accident? NO / YES

(If yes, please inform the front desk of this if you haven't already.)

Name: _____Date:_____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Would you like text reminders? No/Yes Who is your cell phone carrier?_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male / Female Social Security #: _____-_____-_____

Race: American Indian / Asian / Black or African American / Native Islander / White / Decline

Ethnicity: Hispanic-Latino / Non-Hispanic-Latino / Decline Preferred Language:_____

Are you Pregnant? Yes / No Number of Children: _____ Marital Status: _____

Primary Care Physician Name:_____ Clinic Name/Location:_____

Who may we thank for referring you to our office?_____

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body:_____

_____

Do you consume caffeine? No/Yes < 3 Drinks/day 3-6 Drinks/day >6 Drinks/day

Do you consume alcohol? No/Yes Casual Drinker Moderate Drinker Heavy Drinker

Do you smoke? No/Yes Current Smoke (Since :_____) Former Smoker (Quit when_____)

Do you use drugs? No/Yes Recreational (_____) Addiction Former Addict

Do you exercise? No/Yes Daily Weekly Walks Runs Swims

List ALL Allergies (Medications/Food/Environmental) :_____

_____

List ALL Surgeries (DATES INCLUDED):_____

_____

List ALL Medical History conditions:_____

_____

List ALL Medications/Vitamins you are taking (DATE STARTED as well as dosage) If you have a medication list, please provide that instead._____

_____

_____

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Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father: _____ Mother: _____

Brothers: _____Sisters: _____

Son:_____ Daughter:_____

Circle any activities of daily living that are currently affected due to your pain/discomfort

Dressing, Grooming, Walking, Sitting, Standing, Sitting to Standing, In/out of bed, Transfers, Lifting, Climbing Stairs, Housework, Driving, Sleep, Childcare,

Exercises Affected? (list exercise activities)_____ Other:_____

List/Circle all Medical History conditions please read through the full list as it is important to your care and circle NONE if nothing applies.

Constitutional Systems	Unexplained weight loss, night sweats, fatigue, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses, unexplained falls	NONE
Eyes	Visual changes, headaches, eye pain, double vision, blind spots,	NONE
Ears, Nose, Mouth, and Throat (ENT)	Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears, gingival bleeding, toothache, sore throat, pain with swallowing	NONE
Cardiovascular	Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of consciousness, calf pain when walking, high blood pressure, high cholesterol	NONE
Respiratory	Coughing, coughing blood, wheeze, shortness of breath	NONE
Gastrointestinal	Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, vomiting blood, abnormal stool	NONE
Genitourinary	Incontinence, blood in urine, frequent urination, trouble urinating, menopause	NONE
Musculoskeletal	Pain, stiffness, joint swelling, decreased range of motion, arthritis	NONE
Skin/Breast	Itching, rashes, wounds, tumors, eczema, excessive dryness, Breast: pain, soreness, lumps, or discharge	NONE
Neurological	Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control	NONE
Psychiatric	Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality	NONE
Endocrine	Hyperthyroid: prefer cold weather, mood swings, sweaty, diarrhea, weight loss. Hypothyroid: prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin Diabetes: Frequent urination, increased appetite, increased thirst, dizziness, sweating, headache	NONE
Hematological / Lymphatic	Anemia, bruising easily, family history of blood issues, history of blood transfusion	NONE

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For the following, please only fill out/circle what applies

NECK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Which side? Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

UPPER/ MIDBACK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

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For the following, please only fill out/circle what applies

LOW BACK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Which side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

OTHER: _____ Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

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HIPPA – ACKNOWLEDGEMENT OF RECEIPT Notice of Privacy Practices

We at Genesis Chiropractic Wellness and Rehabilitation Center are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPPA Compliance Officer in person or by our main phone number. If you would like a copy of the Notice, please ask. I hereby acknowledge that I have reviewed the HIPPA notice of Privacy Practice document.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

Consent to X-ray and Verification of Non-Pregnancy

I hereby state that to the best of my knowledge I am not pregnant and am not actively trying to become pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I release Genesis Chiropractic Clinic Inc. from any liability and authorize them to complete any radiology examination deemed necessary.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

Communication Method Disclosure and Consent

Genesis Chiropractic Clinic Inc communicates with its patient population in a variety of ways. We use information the patient or the patient's representative/parent provides, including landline phone, cell phone, text messaging, email, fax and U.S. mail. By providing your cell phone number during the registration process, you: 1. Consent and agree to receive telephone calls, text messages and other communications. These calls may be in regard to services received at Genesis Chiropractic Clinic Inc and your financial obligations related to those services. I understand this consent applies to all current and future medical service accounts for which I am the Guarantor. 2. Understand you may be charged for such calls, messages, or other communications by your wireless carrier. 3. I understand it is my responsibility to inform Genesis Chiropractic Clinic Inc if I choose to withdraw this permission. I can withdraw this consent at any time by contacting Genesis Chiropractic Clinic Inc. I have read, fully understand, and agree to the above:

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

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INFORMED CONSENT

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal; to identify and correct subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

1. Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral/extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities

2. Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

3. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

4. Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, do an analysis, and then develop a treatment for the extremity.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral. We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your health!

Chiropractic care, while rare and unlikely, has risk factors. Most are self-limiting but rare serious risk factors include fracture, exacerbation of a disc herniation, and stroke.

Privacy and Sharing of Information

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient 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.

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5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Release

This is to certify that practitioners at Genesis Chiropractic have my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child and, if applicable, will inform Genesis Chiropractic if I am or might be pregnant. If I am pregnant, I consent to receive an x-ray once it is safe to do so.

I hereby authorize any medical facility to release my previous films/images and reports to Genesis Chiropractic for comparative purposes. In addition, I authorize Meier Family Chiropractic to release my films/images to any other facility for comparative purposes or to a radiologist for review of my films/images.

Consent to Care for Minor

If applicable, I authorize providers at Genesis Chiropractic to administer care necessary to my son/daughter.

Insurance & Financial Responsibility

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Genesis Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Genesis Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits.

I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered to me will be immediately due and payable.

I understand that cancellations must be communicated prior to my appointment. A no call/no show will result in a fee except in the event of an emergency. I understand that a no call/no show fee will be collected at the time of my missed appointment.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

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FEES AND PAYMENTS

Payment in full is due at the time services are rendered. We urge patients to be familiar with their chiropractic insurance benefits prior to appointment. Our office staff calls and verifies your insurance benefits if you need to be informed. Co pays and deductibles are due at time of service or your appointment may be rescheduled. If payment arrangements need to be made, please speak with our office staff to make payment arrangements. Billing your insurance company does not ensure payment, in cases of partial payment OR denial (unless stated otherwise by your insurance carrier) you are responsible for the remaining balance. You are responsible to inform our office of any changes to your insurance policy prior to your visit at our facility, not doing so can result in timely filing, in which the unpaid claim will become your responsibility

WELLNESS/MAINTENANCE CARE

Most insurance companies do not pay for maintenance care. Maintenance care is deemed medically unnecessary through insurance companies. Some verbiage your insurance company might use to describe medically unnecessary treatment is as follows:

- Treatment for a chronic condition if there is no reasonable expectation of improvement.
- Treatment to prevent a relapse or exacerbation of a condition (maintenance)
- Treatment dates over a 2-4 weeks interval
- Long term treatment for the same or similar condition

This notice is to inform you of possible non-covered services that you may be responsible for payment.

Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

_____ _____

Printed name of patient or patient's representative/parent Date

_____

Signature of patient or patient's representative/parent

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AUTHORIZED CONSENT FORM

I, _____ authorize the following people to accompany and discuss any and all chiropractic treatment at Genesis Chiropractic Wellness and Rehabilitation Center, INC. This includes any information pertaining to medical treatment, diagnosis, prognosis, and calling and scheduling/canceling appointments.

1. _____ Relationship to Patient _____
   Phone #_____

2. _____ Relationship to Patient _____
   Phone #_____

3. _____ Relationship to Patient _____
   Phone #_____

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent