CALEDONIA CHIROPRACTIC CLINIC

5401 Douglas Ave., Suite A
Racine, WI 53402
PHONE: 262.681.8829
FAX: 262.681.8830

NEW PATIENT INTAKE FORM

Name: _____Nickname: _____

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____Referred by:_____

Primary Phone: _____ H / C / W Alternate Phone: _____ H / C / W

Emergency Contact: _____ Phone: _____

Emergency Contact is your: ❑ Spouse/Partner ❑ Parent ❑ Other: _____

Marital Status: ❑ Single ❑ Divorced ❑ Widowed ❑ Married to: _____

Number of Children: _____ Ages of Children: _____

Employment Status: ❑ Full Time ❑ Part Time ❑ Not Employed ❑ Self Employed ❑ Retired ❑ Military

Occupation: _____ Employer: _____

Student: ❑ No ❑ Full Time ❑ Part Time School Name: _____

Primary Care Physician: _____ Phone: _____

Insurance: ❑ Self ❑ Spouse ❑ Parent ❑ Medicare ❑ Veteran >> Include SSN _____

Policy Holder Name:_____ Date of Birth _____

Primary: _____ Secondary:_____

Is this a "self funded" plan ? ❑ Yes ❑ No If Yes, do you require a referral ❑ Yes ❑ No

TELL US WHAT BROUGHT YOU TO OUR CLINIC

Is this due to a: ❑ Work injury ❑ Personal Injury case ❑ Other: _____

What are your current complaint(s), location (s) and as best as you can describe (severity & frequency).

1) _____ Date it started:_____

2) _____ Date it started:_____

3) _____ Date it started:_____

The overall frequency of your complaints/concerns is:_____% of the day.

Have you had problems in the past with these symptoms/pain? ❑ No ❑ Yes

If Yes, who have you seen for these complaints and when ?

Name:_____ Date: _____

Name:_____ Date: _____

Name:_____ Date: _____

On a scale of (NONE)0-10(WORST), how would you rate your pain/symptoms today? _____

If your symptoms change, are they worse in the: ❑ Morning ❑ Evening ❑ Night ❑ N/A

Are your symptoms/pain getting: ❑ Better ❑ Worse or ❑ Staying the same ?

What makes your symptoms better? _____

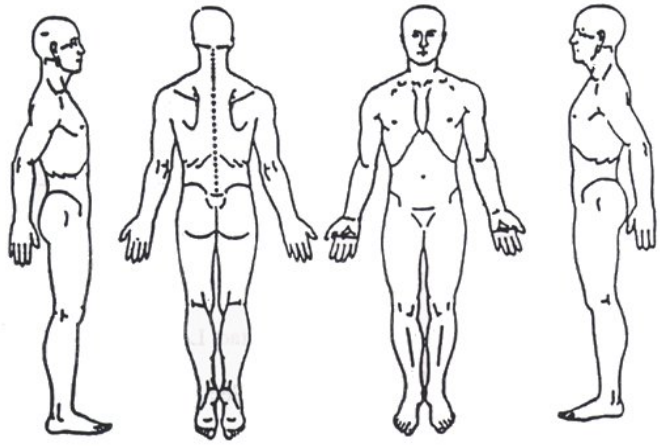
What makes your symptoms worse? _____

On the pictures, please mark where it hurts:

O = For current condition.

X = For condition experienced in the past but has not returned

◇= For condition experienced in the past and has returned.



If your complaints include pain, how would you describe it? (Please check all that apply)

❑ Aching ❑ Burning ❑ Dull ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing

❑ Other:_____

Since your symptoms began, have you had any function changes in:

❑ Bowel ❑ Bladder ❑ Sexual ❑ No changes

Do work activities aggravate your present complaints? ❑ Yes ❑ No ❑ N/A

How often does your job involve lifting? ❑ Never ❑ Occasionally ❑Frequently ❑ Constantly

Other job requirements (please check all that apply): ❑ Bending ❑ Carrying ❑ Stooping

❑ Twisting ❑ Turning ❑ Walking ❑ Other:_____

What is your primary work position? ❑ Seated ❑ Standing ❑ Other: _____

TELL US ABOUT YOUR LIFESTYLE

Which is your dominant hand: ❑ Left ❑ Right ❑ Ambidextrous

Which of the following best describes your stress level: ❑ None ❑ Minimal ❑ Moderate ❑ Extreme

Do you exercise: ❑ No ❑ Yes – how often:_____

Smoking status: ❑ Never smoked ❑ Former smoker ❑ Current smoker-how much:_____

How many caffeinated drinks do you consume: ❑ None ☐ _____ per day.

How many alcoholic beverages you consume: ❑ None ☐ _____ per week.

Using a scale from 0 to 10, how would you rate your health?

"Awful" **0 1 2 3 4 5 6 7 8 9 10** "Amazing"

WOMEN ONLY: To your knowledge, are you pregnant? ❑ No ❑ Yes—Due date:_____

Please indicate which activities of daily living are compromised by your current state of health:

- ❑ Walking
- ❑ Sitting
- ❑ Climbing stairs
- ❑ Chewing
- ❑ Kneeling
- ❑ Sleeping
- ❑ Standing
- ❑ Lifting children
- ❑ Reading
- ❑ Playing instrument
- ❑ Using telephone
- ❑ Running
- ❑ Bending
- ❑ Lying in bed
- ❑ Using computer
- ❑ Exercising
- ❑ Sitting in recliner
- ❑ Sports
- ❑ Swimming
- ❑ Recreational activities
- ❑ Getting into/out of an automobile
- ❑ Driving a car
- ❑ Riding in a car
- ❑ Other travel
- ❑ Sewing or crafts
- ❑ Doing laundry
- ❑ Making beds
- ❑ Vacuuming
- ❑ Washing dishes
- ❑ Ironing
- ❑ Carrying groceries
- ❑ Caring for pets
- ❑ Cooking
- ❑ Mowing lawn
- ❑ Raking leaves
- ❑ Gardening
- ❑ Shoveling
- ❑ Combing hair
- ❑ Shaving
- ❑ In/out of bathtub
- ❑ Brushing teeth
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ **None apply**

Please mark whether you NOW HAVE = ❍ or had IN THE PAST = ❑ any of the following conditions/illnesses:

Now	Have In The Past	
❍	❑	Allergies
❍	❑	Hay fever
❍	❑	Fatigue or weakness
❍	❑	Night sweats
❍	❑	Unexpected weight change
❍	❑	Jaw pain/TMJ
❍	❑	Sleeping Problems
❍	❑	Skin problems
❍	❑	Loss of balance
❍	❑	Dizziness/Lightheadedness
❍	❑	Vertigo
❍	❑	Fainting
❍	❑	Headaches
❍	❑	Seizures
❍	❑	Loss of memory
❍	❑	Vision trouble
❍	❑	Hearing trouble
❍	❑	Ear infections
❍	❑	Ringing/Buzzing in ears
❍	❑	Loss of smell
❍	❑	Loss of taste
❍	❑	Difficulty swallowing
❍	❑	Difficulty Speaking
❍	❑	Sinus trouble
❍	❑	Asthma
❍	❑	Wheezing
❍	❑	Chronic cough
❍	❑	Shortness of breath
❍	❑	Chest pain of pressure
❍	❑	Heart trouble
❍	❑	High blood pressure
❍	❑	Low blood pressure
❍	❑	Cold hands or feet
❍	❑	Abdominal pain
❍	❑	Indigestion/Upset stomach
❍	❑	Excess gas
❍	❑	Heartburn
❍	❑	Constipation
❍	❑	Diarrhea
❍	❑	Nausea/Vomiting
❍	❑	Bedwetting
❍	❑	Urinary pain or frequency
❍	❑	Kidney or bladder trouble
❍	❑	Blood in urine or stool
❍	❑	Menstrual problems or pain
❍	❑	Prostate trouble
❍	❑	Erectile dysfunction
❍	❑	Fertility problems
❍	❑	Excessive thirst
❍	❑	Thyroid problems
❍	❑	Anxiety/Nervousness
❍	❑	Mood swings/Irritability
❍	❑	Mental or emotional difficulty
❍	❑	Depression
❍	❑	Arthritis
❍	❑	Bone Fractures
❍	❑	Dislocated joints
❍	❑	Autoimmune disease
❍	❑	Cancer
❍	❑	Diabetes
❍	❑	Fibromyalgia
❍	❑	Multiple sclerosis
❍	❑	Rheumatic fever
❍	❑	Tuberculosis
❍	❑	Other: _____
❍	❑	**NO CONDITIONS/ILLNESS**

Additional information and/or description: _____

_____

_____

_____

Accidents (Auto, work, personal injury, slip and fall, etc.): _____

_____

Prior illness (Other than colds/flu): _____

_____

Surgeries/Hospitalizations: _____

_____

_____

Please list all medications you are currently taking – this includes prescription, over the counter and vitamin/supplement, pleases include dosage and for what condition.

DRUG	CONDITION	DOSAGE AND FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any drug allergies? ❑ No ❑ Yes – Describe: _____

_____

FAMILY HISTORY

RELATIVE	**ILLNESS**	**AGE**	**CAUSE OF DEATH**
Mother	_____	_____	_____
Father	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
_____	_____	_____	_____

I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and direct my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office. I agree to examination and chiropractic treatment as outlined by the doctor. I understand I may be billed directly for any missed appointments.

_____ _____ _____

Patient or Responsible Party Signature Relationship to Patient Date

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HIPPA POLICY

We are very concerned with protecting your privacy and we will always respect the privacy of your health information.

The federal laws that protect your protected health information ("HIPAA") allow your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- In the event that another party is potentially responsible for the payment of your services(i.e.: Workman's Compensation or Personal Injury Claims);
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

You have the right to review our ***Privacy Policy*** in detail before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Your doctor and members of the practice staff may need to contact you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and to leave messages on your answering machine or with individuals at your home or place of employment.

I acknowledge that I understand the Notice of Privacy Practices as described above on my initial visit. The most current Notice of Privacy Practices is subject to change and is available upon request. We encourage you to read it in full. You may obtain additional copies of our most current notice by requesting it from our staff. If you have any questions regarding the notice of our health information privacy policies, our staff will be happy to assist you.

_____ _____

Print Patient Name or Responsible Party Date

_____ _____

Patient or Responsible Party Signature Relationship to Patient

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Caledonia Chiropractic Clinic to serve the healthcare needs of you and your family. We are pleased to participate in your healthcare and look forward to establishing a lasting relationship as your healthcare provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

ADDRESS CHANGE: It is important that we have your correct address on file. Please advise us any time there is any change to your address, telephone number or other contact information.

INSURANCE: Your insurance contract is between you, your employer and/or the insurance company. Not all services are covered by all contracts. Any questions or complaints regarding your coverage should be directed to your insurance carrier.

INDIVIDUAL FINANCIAL RESPONSIBILITY:

- I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services.
- If I fail to provide current and correct insurance information, I will be responsible for payment of all services provided.
- I understand that Co-pays are due at the time of service.
- I understand that if I am Self-pay, payment in full is due at the time of service.
- In the event that my health plan determines a service to be 'non-payable', I will be responsible for the complete charge and agree to pay the cost of all services provided.

INSURANCE AUTHORIZATION FOR ASSESSMENT OF BENEFITS: I hereby authorize and direct payment of my medical benefits to Caledonia Chiropractic Clinic on my behalf for any services furnished to me by the provider.

AUTHORIZATION TO RELEASE RECORDS: I hereby authorize Caledonia Chiropractic Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me, needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

SCHEDULED APPOINTMENTS WITH THE MASSAGE THERAPIST AND THE CHIROPRACTOR: I understand that a 24-hour notice is required for cancellation of an appointment and should I fail to do such, the fee of the total amount of the appointment may be charged to me. This fee must be paid prior to any additional appointments.

PERSONAL INJURY AND WORKMAN'S COMPENSATION CLAIMS: I understand that if my medical condition involves a personal injury or workman's compensation case, I will notify the provider/staff before my scheduled appointment. All additional documentation will be completed at the time of service. Any additional documentation requested by the provider/staff will be presented within 7 days. Should my claim be denied, I understand I am responsible for all medical charges, either after submission to my insurance or in full if I have no insurance.

EFFECTIVE DATE: *Once you have signed this agreement, you agree to all the terms and conditions herein and the agreement will be in force and effect.*

_____ _____

Print Patient Name or Responsible Party Date

_____ _____

Patient or Responsible Party Signature Relationship to Patient