66 Chiropractic

NEW PATIENT HISTORY INTAKE

To our new patients: *Welcome* to 66 Chiropractic. To help us establish you with our practice, please provide us with your complete health history: body, mind and spirit.

Personal Information

Name: _____ Date of Birth: ____/_____/____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #_____ Cell Phone #_____ Work Phone #_____

Place of work: _____ SSN#: _____

Email: _____ Referred by: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

ALLERGIES:

_____

_____

_____

Current Medications	**Dose**	**Times / Day**

Current Herbs / Vitamins/ Supplements	**Dose**	**Times / Day**

Past Chiropractic History

_____

_____

_____

Devices

Do You Use:

___Eyeglasses _____Contact Lens _____Hearing Aid _____Dentures

___Brace (Neck, Back) _____ Pacemaker _____ IUD, Diaphragm _____Artificial Limbs

CHIEF COMPLAINTS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____

2. _____

3. _____

4. _____

Additional problems or concerns you would like addressed:

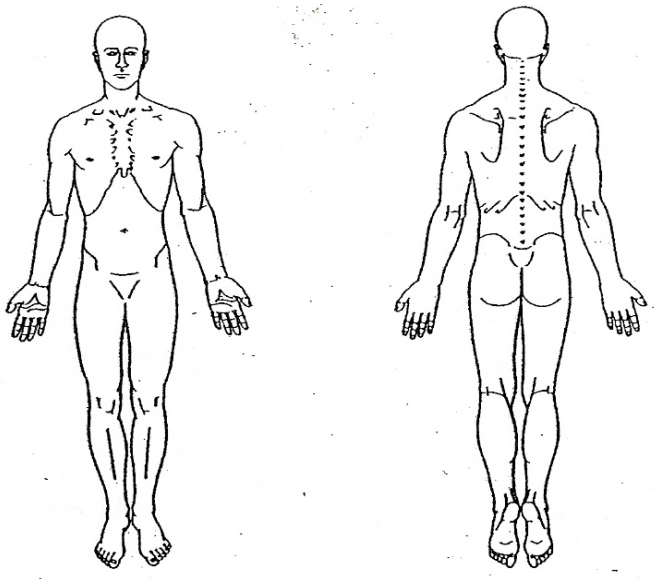
_____

_____

_____

_____Note: we may not be able to address every problem during the course of one visit.

Indicate using an X on the body diagram where you are experiencing your symptoms:



When did your symptoms begin?_____

How did your symptoms begin? _____

_____

Does anything improve your pain? □ Yes □ No

If yes, what helps? _____

Average Pain Intensity:

Last 24 hours: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Last week: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What describes the nature of your symptoms?

□ Sharp □ Burning □ Dull Ache □ Tingling □ Numbness □ Stabbing □ Throbbing

PERSONAL AND FAMILY HISTORY Check those that apply:

	Self	Mother	Father	Grandparents	Siblings
AIDS					
Alcoholism					
Allergies					
Alzheimer's					
Anemia					
Arthritis					
Asthma					
Birth Defects					
Cancer					
COPD					
Diabetes					
Epilepsy					
Glaucoma					
Heart Attack					
Heart Trouble					
High Blood Pressure					
IBS					
Kidney Disease					
Liver Disease					
Mental Illness					
Stroke					
Tuberculosis					
Ulcers					

SOCIAL HISTORY (check those that apply)

Marital status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Education level completed:

- ☐ High school
- ☐ College
- ☐ Professional school
- ☐ Other:

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes? ☐ YES ☐ NO If yes, how many? #_____yrs. _____ packs per day

Did you ever smoke? ☐ YES ☐ NO If yes, when did you quit? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type_____ & _____ drinks per week

Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, which? _____

Do you use recreational drugs? ☐ YES ☐ NO If yes, which? _____

Do you exercise regularly? ☐ YES ☐ NO If no, why? _____

In order to offer you the best care, we need to understand your general health status. Please answer the following questions by checking the boxes as indicated:

C Current: Currently has this condition
P Previously: Had the condition in the past but does not have any problem now
N Never: Never had the condition

GENERAL

	C	*P*	*N*	
1.	☐	☐	☐	Fever
2.	☐	☐	☐	Chills
3.	☐	☐	☐	Night Sweats
4.	☐	☐	☐	Loss of Sleep☐
5.	☐	☐	☐	Fatigue☐
6.	☐	☐	☐	Nervousness
7.	☐	☐	☐	Weight Loss or Gain
8.	☐	☐	☐	Allergies
9.	☐	☐	☐	Bleeding Problem
10.	☐	☐	☐	Anemia
11.	☐	☐	☐	Diabetes
12.	☐	☐	☐	Cancer
13.	☐	☐	☐	Thyroid Disease/Goiter
14.	☐	☐	☐	Alcoholism
15.	☐	☐	☐	Drug Abuse

EAR, EYE, NOSE, THROAT

	C	*P*	*N*	
16.	☐	☐	☐	Poor Vision
17.	☐	☐	☐	Eye Pain
18.	☐	☐	☐	Hearing problems
19.	☐	☐	☐	Nosebleeds
20.	☐	☐	☐	Nose problems
21.	☐	☐	☐	Sinus trouble
22.	☐	☐	☐	Dental Problems
23.	☐	☐	☐	Hoarseness
24.	☐	☐	☐	Tonsillectomy

RESPIRATORY

	C	*P*	*N*	
25.	☐	☐	☐	Difficulty in Breathing
26.	☐	☐	☐	Shortness of Breath
27.	☐	☐	☐	Chronic cough
28.	☐	☐	☐	Spitting Phlegm
29.	☐	☐	☐	Spitting Blood
30.	☐	☐	☐	Wheezing/Asthma
31.	☐	☐	☐	Pneumonia
32.	☐	☐	☐	Tuberculosis

CARDIOVASCULAR

	C	*P*	*N*	
33.	☐	☐	☐	Irregular heart Beat
34.	☐	☐	☐	High Blood Pressure
35.	☐	☐	☐	Chest Pain
36.	☐	☐	☐	Heart Problems
37.	☐	☐	☐	Ankle Swelling
38.	☐	☐	☐	Varicose Veins
39.	☐	☐	☐	Rheumatic Fever
40.	☐	☐	☐	Stroke

SKIN

	C	*P*	*N*	
41.	☐	☐	☐	Itching
42.	☐	☐	☐	Bruising Easily
43.	☐	☐	☐	Change in Mole(s)
44.	☐	☐	☐	Skin Cancer
45.	☐	☐	☐	Hair/Nail Changes
46.	☐	☐	☐	Scar(s)

GASTROINTESTINAL

	C	*P*	*N*	
47.	☐	☐	☐	Poor Appetite
48.	☐	☐	☐	Poor Digestion
49.	☐	☐	☐	Difficulty Swallowing
50.	☐	☐	☐	Belching or Gas
51.	☐	☐	☐	Frequent Nausea/Vomiting
52.	☐	☐	☐	Vomiting Blood
53.	☐	☐	☐	Pain Over Abdomen
54.	☐	☐	☐	Stomach Ulcer
55.	☐	☐	☐	Black or bloody Stool
56.	☐	☐	☐	Liver Problems
57.	☐	☐	☐	Gall Bladder Problems
58.	☐	☐	☐	Jaundice
59.	☐	☐	☐	Diarrhea
60.	☐	☐	☐	Constipation
61.	☐	☐	☐	Bloating
62.	☐	☐	☐	Hemorrhoids
63.	☐	☐	☐	Appendicitis
64.	☐	☐	☐	Hernia

GENITOURINARY

	C	*P*	*N*	
65.	☐	☐	☐	Frequent Urination
66.	☐	☐	☐	Painful Urination
67.	☐	☐	☐	Blood in Urine
68.	☐	☐	☐	Urinary Tract Infection
69.	☐	☐	☐	Kidney Disease
70.	☐	☐	☐	Kidney Stones
71.	☐	☐	☐	Inability to Control Urination
72.	☐	☐	☐	Difficulty Starting Urination
73.	☐	☐	☐	Get up at Night to Urinate
74.	☐	☐	☐	Sexually Transmitted Disease
75.	☐	☐	☐	Sexual Difficulties

MEN ONLY

	C	*P*	*N*	
76.	☐	☐	☐	Testicular Problems
77.	☐	☐	☐	Prostate Problems

WOMEN ONLY

	C	*P*	*N*	
78.	☐	☐	☐	Painful Periods
79.	☐	☐	☐	Excessive Flow
80.	☐	☐	☐	Irregular Cycles
81.	☐	☐	☐	Vaginal Burning/Itching
82.	☐	☐	☐	Hot Flashes

83. Date of Last Menstrual Period

_____

FOR MEN AND WOMEN

84. ☐ ☐ ☐ Breast Lump or Pain

NEUROLOGIC

	C	*P*	*N*	
85.	☐	☐	☐	Weakness
86.	☐	☐	☐	Twitching
87.	☐	☐	☐	Tremor
88.	☐	☐	☐	Headache
89.	☐	☐	☐	Fainting
90.	☐	☐	☐	Dizziness
91.	☐	☐	☐	Convulsions
92.	☐	☐	☐	Epilepsy/Seizures
93.	☐	☐	☐	Numbing/Tingling
94.	☐	☐	☐	Arm/leg Pain
95.	☐	☐	☐	Mental disorder

MUSCULOSKELETAL

	C	*P*	*N*	
96.	☐	☐	☐	Neck Stiffness/Pain
97.	☐	☐	☐	Pain between Shoulders
98.	☐	☐	☐	Low Back Pain
99.	☐	☐	☐	Painful Joints
100.	☐	☐	☐	Muscle Ache/Soreness
101.	☐	☐	☐	Spinal Curvature
102.	☐	☐	☐	Arthritis

TRAUMA

Indicate if you ever had or been involved in any of the following

	YES	*NO*	
103.	☐	☐	Car accident
104.	☐	☐	Major fall
105.	☐	☐	Broken bones
106.	☐	☐	Head Trauma
107.	☐	☐	Sports

If you answered yes to 103-107 please explain below:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
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_____
_____

YOUR PRIMARY CARE DOCTOR'S NAME _____
PHONE #_____

YOUR PRIMARY CARE DOCTOR'S ADDRESS_____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? ( ) Yes ( ) No

EMERGENCY CONTACT: _____PHONE # _____

RELATIONSHIP: _____

This history record has been designed to facilitate our patient's continuity of care at 66 Chiropractic. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

Patient/Guardian signature who filled out the history

_____ Date: _____

Physician Signature

_____ Date: _____

66 Chiropractic

2327 S Dirksen Pkwy
Springfield, IL 62703

Financial Agreement

Third Parties:
If you have health insurance, were injured on the job, in an automobile accident or some other personal injury, you may have other options. In general, we expect payment of deductibles, co-payments and co- insurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

- I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
- **All co-payments must be paid at the time of service**.
- I am responsible for obtaining any and all required referrals for service.
- I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until **after** the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
- I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY: I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for non-covered services. The Provider will file my insurance
claim only as a courtesy.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Provider to release any information required to process my claim.

Billing:
We have a payment at time of service policy however we understand that circumstances sometimes change. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. Balances beyond 30 days will be charged a billing fee of 9% per month, plus any legal or collection fees.
A check returned from our financial institution is subject to a returned check fee. The current fee is $25.00 per return.

Collection Consideration:
I agree if my account becomes past due and is turned over for collection there will be a collection fee of 35.5% of the outstanding balance added for which I will be liable for, in addition to legal, attorney fees and court costs.

Missed Appointments:
I understand that if I have an appointment and fail to cancel it at least twenty-four hours in advance, during the business hours of this office, that I will be charged a $25 fee for the doctor's time. I understand that insurance companies do not typically pay this fee and that this responsibility is mine alone.

Agreement:
This is the entire financial agreement between **66 Chiropractic** and the patient below. I have read this agreement, understand it and agree with its provisions.

_____ _____

Patient's Name Printed | Guardian Signature if applicable

_____ _____

Patient Signature | Date Signed

66 Chiropractic

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:
By_____
Signature of Parent/Guardian (circle one)

66 Chiropractic
2327 S Dirksen Pkwy
Springfield, IL 62703
Office: (217) 544-3628

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on _____ by Dr. Stephen C. Unverzagt, D.C or Dr. Travis R. Taylor D.C.

I have had an opportunity to discuss with Dr. Stephen C. Unverzagt, D.C, Dr. Travis R. Taylor D.C. or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts know to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications, which have been alleged. These include but are not limited to: fractures, disk injuries, strokes, dislocation, sprains, minor soreness and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

_____

Patient Name Date

_____

Patient Signature Relationship of authority if not signed by Patient

DOCTOR'S NOTES

Patient counseled by the use of the following:

Discussion _____

Other (please specify) _____

Signature of Doctor or Other _____