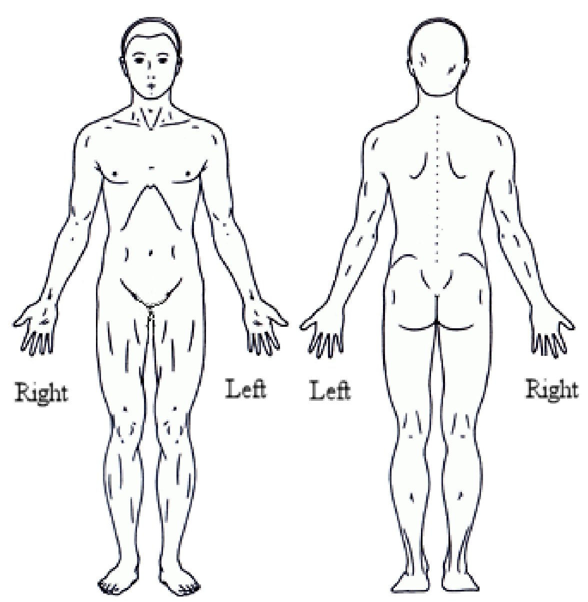
Woodbury Family Chiropractic

Name______________________________ Age__________ Height ________ Weight ________ lbs. Today's Date___/___/_____
Address____ City___________________ State______ Zip_____________
Cell#______________________________Home#__________________________________Date of Birth ___/___/______ Sex: M F
E-Mail Address: ___________________________________How did you hear about us?_________________________________
Occupation/Employer ____ Phone (Work)__________________________
Insurance Company____Phone__________________________
Insured's Name ____ Insured's Date of Birth _________________________
Insured's Group # ___________________________ Insured's address same? Y N
Spouse's Name _______ ____________________________Children's Names/Ages____________________________________
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _______________
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____________________

HEALTH REPORT:

Reason for seeking care: ____
List any other doctors seen for this: ____
List any diagnosis and type of treatment: ____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____________________________________
List the names of any relatives that have or have had a similar problem: ____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: ____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: ____
Are you currently taking medication? __ Yes __ No list medications: ____
____
Have you taken medication in the past? __ Yes __ No list medications ____
List conditions you are taking medications for: ____
List the approximate dates of any surgery or treated conditions:____
____
Family History: Health conditions, age of death and cause of death.
Father: ____
Mother: ____
Brother/s & Sister/s: ____
Do you smoke Y/N ____ • Alcohol Y/N __Daily __Weekly __Social Occasions • Caffeinated drinks per day _____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____________________________________



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel discomfort:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^

When did the current complaint begin? ________________
How long have you had these symptoms?_______________
What activities aggravate your condition/pain?___________
What activities lessen your condition/pain?______________
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?__________
Sleep?__________ Routine?_______Other?____________
Is this condition progressively getting worse?___________

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _______________

FOR WOMEN ONLY
__ Birth Control _________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this time Y / N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature____ Date___________________________

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, ___________________________ [Name of Individual] consent to Woodbury Family Chiropractic, “the Practice’s”, use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_______________________________________ ________________________________

Patient Signature or Personal Representative Date

____

Name of Patient or Personal Representative

Financial Policy

WELCOME TO OUR OFFICE! Our goal is to provide you with the best possible chiropractic care, and to have it be a pleasant, positive experience for all of us. In order to serve you more effectively, we have established a few policies.

APPOINTMENTS: Your appointments are times reserved and committed exclusively for you. We realize that emergencies do occur, and appointments must sometimes be changed. Charges may be made for missed appointments and appointments cancelled without 2 hours advance notice.
PAYMENTS: Payment is due at the time services are rendered, unless other arrangements have been made in advance. We accept cash, check, or VISA/MC/DISCOVER. Returned checks are subject to a $25 service charge. Any account that becomes delinquent will be subject to collections service.
INSURANCE: We must emphasize that as chiropractic providers, our primary relationship is with you. As a service to our patients, we do accept assignment of insurance benefits on most policies. In addition, we are participating providers with several insurance carriers and payers. You are responsible for payment of your co-pay at the time of service. If your deductible has not been met, you are responsible for full payment until it has been met; then, only your portion thereafter. Once the claim has been processed by your insurance provider, we will bill you your patient responsibility portion. Payment is due within 30 days of this bill.

** NOTE: We are happy to assist you in verifying chiropractic benefits of your policy. All insurance companies begin verification with a pre-recorded message which states: *"This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment."*

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. This form of treatment is typically performed by hand or with a mechanical instrument upon your body in such a way to improve motion and function within your joints. After performing a physical examination and medical consultation, the Doctor will make every effort to screen for contraindications to this type of care. However, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.
Please ask questions before signing this form if there is anything that is unclear.
I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you IMMEDIATELY of any changes in my health status or the above information, including a change of insurance policies.

Patient Signature_______________________________________ Date ______________________

AUTHORIZATION FOR CARE OF MINOR
I hereby authorize the Doctor of Woodbury Family Chiropractic to administer care as they so deem necessary to my son / daughter.

Responsible party (or guardian)
Signature ____ Date ______________________