Woodlake Chiropractic

New Patient Information

Name: _____

Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell Phone: _____

Birth date: _____ Age: _____

Gender: _____ # of Children: _____

Employer: _____

Work Address: _____

Work Phone: _____

Type of Work: _____

Marital Status: _____

SSN (Medicare or WC Patient): _____

Email address: _____

Would you like to receive our office newsletter and our monthly promotions by email? ( )Yes ( )No

Payment method for first visit:

( ) Cash ( ) Check ( ) Credit Card

Reason for the Visit

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Is the purpose of this appointment related to:

( ) Job ( ) Sports ( ) Auto ( ) Fall

( ) Home Injury ( ) Chronic discomfort ( )Other

Please explain: _____

If job related, have you made a report of your accident to your employer? ( )Yes ( )No

When did this condition begin? _____

Has this condition:

( )Gotten worse ( )Stayed constant ( )Comes and goes

Does this condition interfere with:

( )Sleep ( )Daily routine ( )Other activities

Please explain: _____

Has this condition occurred before? ( )Yes ( )No

Please explain: _____

Have you seen other doctors for this condition?

( )Yes ( )No

Doctor's Name(s): _____

Type of treatment: _____

Results: _____

_____

Emergency Contact / Spouse Info

Name: _____

Employer: _____

Work Phone: _____

Cell Phone: _____

General Questions

Do your mother, father, brother sister, children have similar problems? ( ) Yes ( ) No

Do you have a history of cancer? ( ) Yes ( ) No

Do you have history of corticosteroid use? ( )Yes ( ) No

Have you experienced in the past, or do you now have, bowel and bladder problems? ( ) Yes ( ) No

Experience with Chiropractic

Who can we thank for referring you to this office? _____

Have you been adjusted by a Chiropractic before? ( )Yes ( )No Reasons for those visits: _____

Doctor's Name: _____ Approximate date of last visit: _____

Have any adults in your family seen a Chiropractor? ( )Yes ( )No

Have any children in your family seen a Chiropractor? ( )Yes ( )No

Phone 612.866.9194 Fax 612.866.9963 www.woodlakechiro.com email: woodlakechiro@yahoo.com

Woodlake Chiropractic

Goals of My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

( ) **Relief care** – Symptomatic relief or pain or discomfort

( ) **Stabilization care** – Correcting and relieving the cause of the problem as well as the symptoms

( ) **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care, in combination with Massage Therapy and Nutrition.

( ) **I want the Doctor to select the type of care appropriate for my condition.**

_____ _____

Patient's signature Date

Health Conditions

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

( )Severe or frequent headaches
( )Sinus problems
( )Dizziness
( )Loss of sleep
( )Pain between shoulders
( )Frequent neck pain
( )Numbness in arms/legs/hands
( )Pain in arms/legs/hands
( )Lower back problems
( )Digestive problems
( )Heart surgery/pacemaker
( )Heart attack/stroke
( )Heart murmur
( )Congenital heart defect
( )High/Low blood pressure
( )Difficulty breathing
( )Asthma
( )Tuberculosis

( )Alcohol/drug abuse
( )Venereal disease
( )HIV/AIDS
( )Ulcers
( )Arthritis
( )Diabetes
( )Shingles
( )Kidney problems
( )Hepatitis
( )Cancer
( )Chemotherapy
( )Rheumatic fever
( )Psychiatric problems
( )Thyroid problems
( )Surgeries
( )_____

For women:

Are you pregnant? ( )Yes ( )No
Are you nursing? ( )Yes ( )No
Are you taking birth control? ( )Yes ( )No
Do you experience painful periods? ( )Yes ( )No
Do you have irregular cycles? ( )Yes ( )No
Do you have breast implants? ( )Yes ( )No

Health Habits

Do you smoke? ( )Yes ( )No
If yes, how many packs per day?_____
Do you drink alcohol? ( )Yes ( )No
If yes, how many drinks per day? _____
Do you drink caffeine? ( )Yes ( )No
If yes, how many cups per day?
How much water do you drink daily? _____oz./day
Do you exercise regularly?
( )Daily ( )Moderate ( )No
Do you wear:
( )Heel lifts ( )Sole lifts ( )Inner soles ( )Arch supports

Current Medications

( )Muscle relaxers
( )Insulin
( )Blood pressure medicine
( )Blood thinners
( )Pain killers (including aspirin)
( )Cholesterol medicine
Vitamins: _____
Supplements: _____
Other medications: _____
_____

Authorization for Care

I hereby authorize the doctors of chiropractic in this office, including whomever they deem their assistants, to work with my condition through the use of adjustments and procedures the doctor deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient's signature Date Guardian or spouse's signature authorizing care Date

Who should receive bills for payment on your account?

( )Patient ( )Spouse ( )Parent ( )Worker's Comp ( )Auto Insurance ( )Medicare ( )Medicaid

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Woodlake Chiropractic

Photo Consent

I give permission to Woodlake Chiropractic doctors and staff to use my photographs, videos and any handwritten/emailed testimonials from me for advertising purposes both internal and external. This would include but is not limited to: newsletters, print ads, websites, in office use, and any other promotional item for the office. Should I request to have my photos, videos or written testimonials removed, I will inform the doctors in writing.

_____ _____

Signature of Patient or Guardian Date

X-ray Consent

I hereby give my consent to Woodlake Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge; I am not pregnant. I have read and understood all the above information.

_____ _____

Signature of Patient or Guardian Date

Terms of Acceptance

It is essential that the patient seeking chiropractic care and the Chiropractor whom they select are both working towards the same therapeutic goal. Below we outline our objective and our method in order to prevent confusion or disappointment.

Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or altered nerve function that interferes with the body's innate ability to maintain health.

An **Adjustment** is the specific application of forces to facilities the body's correction of subluxation. Our chiropractic method of correction utilizes specific manual and instrument-assisted adjustments to the spine, other joints in the body, and the nervous system to assist the body in returning to a state of maximum health. Modalities such as exercise, stretching, and soft tissue therapies may be used to achieve the optional well-being of the patient.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Financial Policies

PAYMENT IS DUE AS SERVICE IS RENDERED

However, as a courtesy to our patients, we do allow other payment options withing guidelines of our policy.

1. CASH: We accept cash, check, Visa, Mastercard, American Express, and Discover. Payments for services are due at the time the services are rendered, unless payment arrangements have been approved in advance by our staff. Returned checks maybe subject to a $15.00 service charge in additional to penalties incurred by the banking institution. Savings plans are available for children, families, and adults desiring regular treatments.
2. GROUP INSURANCE: Patients are responsible for payment in full at the time of and for the first visit. If out of network, the patient is responsible for submitting all claims to their insurance company for reimbursement.
3. WORKER'S COMPENSATION: Patients are required to fill out a worker's compensation questionnaire. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases.
4. ACCIDENT/PERSONAL INJURY: Patients are required to complete a personal injury questionnaire and/or an accident report form. If you have been involved in a motor vehicle accident, it is important that your report the accident to your insurance agent. You must ask for a claim number and obtain the appropriate billing information. If an attorney is involved, please let us know.
5. MEDICARE: We will submit all claims to Medicare for you. You are responsible for payment of all services at the time of service. This would include x-rays, examinations, adjustments, supports, nutrition, and therapy. You must provide your Medicare card at the first visit. If you have a secondary insurance, we will bill Medicare, but you are responsible for submitting any unpaid balance to your secondary insurance.
6. MEDICAL ASSISTANCE: We do not accept assignment for Medical Assistance in our office. Savings plans are available for people on social security.

Acknowledgment of Receipt of Privacy Practices

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Woodlake Chiropractic which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

If you have any questions or comments regarding our terms, policies, we are happy to assist you.

_____ _____ _____

Name of Patient Signature of Patient or Guardian Date

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