New Patient Forms

Patient Name: ____Date: ____________

Address______________________________City____________ State _____ Zip Code ________

Cell Phone ____________________Other Phone____________

Email Address: ______________________________

Sex M F X Marital Status M S D W Date of Birth__________ Age_____ SS#________________
Occupation____
Employer____

Referred by: ____________________________

Have you ever received Chiropractic Care? Yes No If yes, when? ____________________
Name of most recent Chiropractor: ______________________________________

Reasons for seeking chiropractic care:

Primary reason:
____

Secondary reason:
____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):
____
____
____

INTEGRITY CHIROPRACTIC HEALTH COMES FROM WITHIN

NEW PATIENT HISTORY FORM. ***Please Start at your head and work your way down***
Symptom 1 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ______________________________
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ______________________________
- Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? ______________________

- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
- Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (Circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

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□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? __________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize the office of Integrity Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Integrity Chiropractic** for services performed.

Patient or Guardian Signature ______________________________
Date_______________________

Past Health History:

A. Please indicate if you have a history of any of the following:
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders

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□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other __________
□ None of the above

B. Previous Injury or Trauma:

____

Have you ever broken any bones? Which?

____

C. Allergies: ____

D. Medications:

Medication Reason for taking

____
____
____

E. Surgeries:

Date Type of Surgery

____
____
____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____
____
____

1. Family Health History:

Please indicate if you have a family history of: (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other ______________ □ None of the above

Deaths in immediate family: ____
Cause of parents or sibling death: Age at death

____
____

Social and Occupational History

A. Job description: Work Schedule:

____

B. Recreational activities: Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet)

____

HIPAA NOTICE OF PRIVACY PRACTICES

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INTEGRITY CHIROPRACTIC HEALTH COMES FROM WITHIN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____ __________________________
Signature of Patient of Representative **Date**

____
Printed Name

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Consent of Treatment and Privacy Policy

I, ____Authorize Dr. Jill Bodensteiner DC to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments and procedures.

Release of Information

Integrity Chiropractic may disclose information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires that information in order to fulfill an obligation benefiting the patient.

Responsibility of Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that the doctor may bill my health insurer for the services; such billing does not relieve me of my responsibility to pay for the services. If insurance billing results in a credit to your account it will be refunded to you.

X-Ray

The Gonstead technique utilizes a full spine film to analyze the position of the vertebrae and pelvis. The x-ray is essential to performing a specific adjustment but may not be considered medically necessary.

Pregnancy Release: This is to certify to the best of my knowledge I am not pregnant and the doctor and their staff have my permission to perform an x-ray.

Initials _________

Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serous conditions such as cerebral vascular accidents. I also understand that he doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personal the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor an/or intern will perform an examination in order to minimize any risk of care, however, I do not expect the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

CVA Signs

If during your visit you suffer from any of the following please notify the doctor or staff immediately:

- Sudden severe pain in the side of your head and/or neck
- Vision problems
- Numbness, loss of feeling, or abnormal feeling
- Weakness, clumsiness, or loss of strength
- Dizziness

6. Hearing problems
7. Disorientation or confusion
8. Speech problems
9. Loss of consciousness

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

Signature: ____ Date: ____

All questions regarding the chiropractor's objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

____

Signature **Date**

Financial Policy

Please take a few minutes to review the following information prior to your appointment.

We hope you understand our financial policies are established to assure the financial resources needed to maintain this chiropractic office for all of our patients. We will work with you to ensure that your chiropractic care does not become a financial burden.

We accept cash, personal checks, and credit cards for payment on your account.

About Health Insurance

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not with your insurance company.

PPOs

If you have selected Integrity Chiropractic because we are on your plan, be aware that we have done this as a service to you in efforts to get you reimbursed for what you pay into your insurance. Whatever your insurance does not cover of our fees, regardless of your plan, you are still responsible.

Signature of Patient **Date**

Authorization to Contact You

It may be necessary for Integrity Chiropractic to contact you at home or at work in the event the doctor is out of the office, we need to reschedule, or to remind you of an appointment. By signing below, you give us authorization to contact you for any of the aforementioned circumstances.

Signature **Date**

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integritychiropracticsc@gmail.com ph 970-577-0007

Cancellation/Missed Appointment Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting treatment as we normally have a waiting list.

If you need to cancel your appointment, we respectfully request at least an hour notice. Any cancellation made less than one hour before your scheduled appointment time will result in a $25 cancellation fee. This fee will not be covered by your insurance company.

______________________________________ ____________________
Signature **Date**

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