WELLNESS & CHIROPRACTIC CARE

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY) _____ **Patient Number** (office use only) _____

Your Last Name _____ **Your Social Security Number** _____ **Birth Date (MM/DD/YYYY)** _____ **AGE** _____

Your First Name _____ **Your Middle Name (or initial)** _____ **Gender** ◯ Male ◯ Female

Address _____ **Marital Status** ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

City _____ **State/Province** _____ **ZIP/Postal Code** _____

Home Phone _____ **Cell Phone** _____ **Spouse's Name** _____

Email Address _____ **Child's Name and Age** _____

Emergency Contact _____ **Emergency Contact's Phone** _____ **Child's Name and Age** _____

Your Occupation _____ **Child's Name and Age** _____

Your Employer _____ **Work Phone** _____

Address _____ **May we contact you at work?** ◯ Yes ◯ No

City _____ **State/Province** _____ **ZIP/Postal Code** _____ **Preferred method of contact?** ◯ Home Phone ◯ Cell ◯ Work Phone ◯ Email

Phone

Primary Care Provider's Name _____

Insurance Carrier _____ **Policy Number** _____

Who carries this policy?

Insured's Last Name _____ **Birth Date (MM/DD/YYYY)** _____ ◯ Self ◯ Spouse ◯ Parent

Insured's First Name _____ **Insured's Middle Name (or initial)** _____

Insured's Employer _____

Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____ **Employer's Phone** _____

WELCOME TO OUR OFFICE

NAME _____ **DOB** _____ **DATE** _____

You are the reason we are here!

We are committed to earning your trust and confidence by giving you individualized and considerate healthcare. Dr. Anita Knopp and staff always welcome comments about your treatment here at our office and suggestions so that we can learn to serve you better.

Who referred you to our office, so that we may thank them? _____

***Please arrive on time** so we can give you the entire time reserved for you.
*** We require 24 hour notice to cancel** your appointment.
NOTE: It is our policy to charge for no-shows or late cancellations.
***Please respond promptly to statements** mailed to you.
You may pay by cash, check or credit card. There is a fee of $20.00 charged for each returned check.
Delinquent accounts are transferred to a collection agency.

Please check below those that apply to you: (A separate form will need to be filled out & signed at time of visit.)

_____**Health Insurance:** I plan to use my health insurance to pay my fees (Note: not all plans are accepted by this office.) **Please bring your current insurance card(s) with you.** *Please pay insurance Copays and Deductibles at the time of service.

_____ **Workplace injury Claims:** In order for a Workers' Compensation claim to be filed by this office, we must verify the case with the employer and the insurance company. You must furnish us with the claim information and date of injury to do so.

_____ **Personal Injury Insurance:** In order for our office to file claims to an automobile or homeowner's insurance company, you must furnish us with all the necessary claim information and date of accident.

_____ **Medicare:** This office does participate with Medicare. We ask you to pay the deductible if applicable and the contractual allowed amount of 20% for the adjustments. Exams and x-rays are not covered by Medicare. Ask our staff for more information on discounted fees for these services.

_____ **Self-Pay Patient:** I will be paying fees directly to this office at time of visit.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE ABOVE POLICIES

_____ _____

SIGNATURE **DATE**

Revised 3.7.2020

New Patient History

Patient Name _____ DOB _____ Date_____

1) What is your Primary complaint (1 or 2 regions)? (i.e. low back)

_____

2) When did your symptoms start (provide date)?_____

3) Did your symptoms come on suddenly or gradually?_____

4) Do you know what may have caused your symptoms?(i.e. work, auto, sports)_____

_____

5) Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

No mild moderate severe

Sitting----------○------○------○---------○
Rising out of chair------○------○------○---------○
Standing----------○------○------○---------○
Walking----------○------○------○---------○
Lying down----------○------○------○---------○
Bending over----------○------○------○---------○
Climbing stairs----------○------○------○---------○
Using a computer-------○------○------○---------○
Getting in/out of car---○------○------○---------○
Driving ----------○------○------○---------○
Looking over shoulder-○------○------○---------○
Caring for family--------○------○------○---------○

No mild moderate severe

Grocery shopping------○------○--------○----------○
Household chores------○-----○------ ○---------○
Lifting objects----------○-----○------ ○---------○
Reaching overhead----○-----○------ ○---------○
Showering/bathing-----○---- -○------ ○---------○
Dressing myself---------○------○------ ○---------○
Love Life----------○------○------○---------○
Getting asleep----------○------○------○---------○
Staying asleep----------○------○------○---------○
Concentration----------○---- -○------○---------○
Exercises----------○----- ○------○---------○
Yardwork----------○----- ○-------○---------○

6) Review of Systems (Circle 'have' or 'had' or 'N/A' if applicable)

a) Musculoskeletal N/A

Had Have **Osteoporosis|** Had Have **Arthritis|** Had Have **Scoliosis|** Had Have **Neck pain|** Had Have **Back problems|** Had Have **Hip disorders|** Had Have **Knee injuries|** Had Have **Foot/ankle pain|** Had Have **Shoulder problems|** Had Have **Elbow/wrist pain|** Had Have **TMJ issues|** Had Have **Poor posture|**

b) Neurological N/A

Had Have **Anxiety|** Had Have **Depression|** Had Have **Headache|** Had Have **Dizziness|** Had Have **Pins and needles|** Had Have **Numbness|**

c) Cardiovascular N/A

Had Have **High blood pressure|** Had Have **Low blood pressure|** Had Have **High cholesterol|** Had Have **Poor circulation|** Had Have **Chest pain|** Had Have **Excessive bruising|**

d) Respiratory N/A

Had Have **Asthma|** Had Have **Apnea|** Had Have **Emphysema|** Had Have **Hay Fever|** Had Have **Shortness of breath|** Had Have **Pneumonia|**

e) Digestive N/A

Had Have **Anorexia/bulimia|** Had Have **Ulcer|** Had Have **Food sensitivities|** Had Have **Heartburn|** Had Have **Constipation|** Had Have **Diarrhea|**

f) Sensory N/A

Had Have **Blurred vision|** Had Have **Ringing in ears|** Had Have **Hearing loss|** Had Have **Chronic ear infections|** Had Have **Loss of smell|** Had Have **Loss of Taste|**

g) Skin N/A

Had Have **Skin cancer|** Had Have **Psoriasis|** Had Have **Eczema|** Had Have **Acne|** Had Have **Hair loss|** Had Have **Rash|**

h) Endocrine N/A

Had Have **Thyroid issues|** Had Have **Immune disorders|** Had Have **Hypoglycemia|** Had Have **Frequent infection|** Had Have **Swollen glands|** Had Have **Low Energy|** Had Have **PMS symptoms|**

i) Genitourinary N/A

Had Have **Kidney stones|** Had Have **Infertility|** Had Have **Bedwetting|** Had Have **Prostate issues|** Had Have **Erectile dysfunction|**

j) Constitutional N/A

Had Have **Fainting|** Had Have **Low libido|** Had Have **Poor appetite|** Had Have **Fatigue|** Had Have **Sudden weight gain|** Had Have **Sudden weight loss|** Had Have **Weakness|**

7) List any surgeries (with month/year) or N/A:

_____ _____ _____ _____

_____ _____ _____ _____

8) List any injuries (Concussions, fractured/broken bones, accidents) include month/year or N/A:

_____ _____ _____ _____

_____ _____ _____ _____

Patient Name _____ DOB _____ Date_____

9) Illnesses (Circle 'Had' or 'Have' or 'N/A')

Had	Have	N/A	HIV/AIDS	Had Have N/A	Glaucoma
Had	Have	N/A	Alcoholism	Had Have N/A	Goiter
Had	Have	N/A	Allergies	Had Have N/A	Gout
Had	Have	N/A	Arteriosclerosis	Had Have N/A	Heart Disease
Had	Have	N/A	Cancer	Had Have N/A	Hepatitis
Had	Have	N/A	Chicken Pox	Had Have N/A	Malaria
Had	Have	N/A	Diabetes	Had Have N/A	Measles/Mumps
Had	Have	N/A	Epilepsy	Had Have N/A	Multiple Sclerosis
Had	Have	N/A	Polio	Had Have N/A	Rheumatic Fever
Had	Have	N/A	Scarlet Fever	Had Have N/A	Sexually Transmitted Disease
Had	Have	N/A	Stroke		

10) Social History

Alcohol use ◯Daily ◯ Weekly - How much?_____ ounces
Coffee use ◯Daily ◯ Weekly - How much?_____ ounces
Tobacco use ◯Daily ◯ Weekly - How much?_____
Exercising ◯Daily ◯ Weekly – Type/Frequency?_____ Cardio / free weights
OTC Pain relievers ◯Daily ◯ Weekly - How much?_____
Soft drinks ◯Daily ◯ Weekly - How much?_____ ounces
Water intake ◯Daily ◯ Weekly - How much?_____ ounces
Hobbies _____

11) Has this current condition interfered with work/career?_____
12) What is the major stressor in your life?_____
13) How many hours do you sleep on average per night?_____
14) What is the approximate age of your mattress? _____ **Pillow?** _____
15) What is your preferred sleeping position?_____
16) Daily eating habits: ◯ Skip breakfast ◯2 meals ◯3 meals ◯snacking between meals
17) What would be the most significant thing you could do to improve your health?
_____

18) Occupation _____ **How long ?** _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, **print** child's full name: _____

Signature_____ Date_____

How to Prepare for Your Chiropractic Visit

Your First visit

- Wear active clothing without metal, such as yoga or sweat pants
- Bring medication and allergy list if applicable
- Bring PCP contact information

Your Second Visit

- If possible bring somebody with you to this visit, a family member or friend. There will be a lot of information to go over.
- Please bring a cell phone with you to take pictures of your X-rays.

For every visit

- Please remove coats, sweatshirts, turtlenecks, scarfs and other extra layers prior to all treatments
- Please remove jewelry
- If you have long hair please tie up with a metal accessories
- Please remove your shoes when you enter the office; to help reduce environmental toxins in the building
- Bring insurance card(s)
- Bring method of payment for services rendered

Cancellation Policy

Here at Wellness and Chiropractic Care we understand that there are interruptions to your daily life, such as; illnesses, car problems, traffic delays, work issues, etc. These interruptions may be a reason to cancel your appointment.

Our commitment is to provide a quality chiropractic experience for all of our patients. Out of consideration for other patients, staff and the Doctor's time we are adopting the following policies:

Arrival to our practice

Please arrive 20 minutes prior to your scheduled appointment, this allows time for questions, to complete any necessary forms and preparation for your appointment (remove layers of clothing, jewelry, shoes etc.).

All services offered have a specific time schedule and early arrival allows for an enjoyable and relaxed experience. If a late arrival is inevitable, your appointment may be rescheduled in order to keep on schedule for other patients.

Cancellation Policy

We have a 24 hour cancellation policy with a $25.00 charge. Full credit will be given if the appointment is cancelled or rescheduled 24 hours prior to the scheduled appointment time. No refund will be given for less than a 24 hour cancellation notice. Consideration offered for emergencies or unforeseen events.

Late Arrival Policy

As a courtesy to other patients and staff, appointments will be automatically cancelled 15 minutes after scheduled start time and charged according to our cancellation policy. We cannot guarantee that late arrivals will receive an extension of their scheduled appointment. In special cases and when our schedule will allow, we may be able to accommodate another appointment, this will be at our discretion and only with proper advanced notification of your late arrival.