620 Jackson Street, Sauk City, WI 53583
PHONE: (608) 370-7328 ● FAX #: (608)-237-3119 ● EMAIL: ccnwisconsin@gmail.com

NEW PATIENT INTAKE PAPERWORK

1 Patient Information

Legal Name: (Last)_____ (First)_____ (M.I.) _____

Marital Status: □ Single/Never Married □ Married □ Divorced □ Domestic Partner □ Widowed

Date of Birth: _____ Height: _____ Weight: _____

Gender: □ Male □ Female Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Emergency Phone: _____

Whom may we thank for referring you? _____

Authorization to Release Records

Name of Family Doctor:_____ Location: _____ Phone:_____

I authorize Center of Chiropractic Neurology to inform my family doctor that I am receiving treatment here. _____ (init.)

2 Medications

(If lengthy, please bring a list)

1) _____
2) _____
3) _____

Pharmacy Name: _____

Pharmacy Phone: _____

□ None

Vitamins/Supplements:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

□ Daily □ Weekly □ Occasionally

□ None

Allergies

1) _____
2) _____
3) _____
4) _____

How often do they occur?

_____

□ None

3 Family History

Bleeding Disorder	□ Yes □ No	High Blood Pressure	□ Yes □ No
Clotting Disorder	□ Yes □ No	Kidney Disease	□ Yes □ No
Cancer	□ Yes □ No	Migraines	□ Yes □ No
Diabetes	□ Yes □ No	Osteoporosis	□ Yes □ No
Heart Disease	□ Yes □ No	Autoimmune Disease	□ Yes □ No
Stroke	□ Yes □ No	Other: _____	
Thyroid Disease	□ Yes □ No	_____	

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4 Medical History

Name and Address of other doctor(s):

_____

Date of Last: Physical Exam _____ Spinal X-ray_____ Chest X-ray _____
MRI, CT Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have expereienced each of the following and complete the information below:

AIDS/HIV	□ Yes	□ No	Chemical Dependency/ Alcoholism	□ Yes	□ No	Hernia	□ Yes	□ No	Pinched Nerve	□ Yes	□ No
Allergies	□ Yes	□ No				Herniated Disk	□ Yes	□ No	Pneumonia	□ Yes	□ No
Anemia	□ Yes	□ No	Chicken Pox	□ Yes	□ No	Hypertension	□ Yes	□ No	Prostate Problem	□ Yes	□ No
Anxiety/Depression	□ Yes	□ No	Clotting Disorder	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Psychiatric Care	□ Yes	□ No
Appendicitis	□ Yes	□ No	Diabetes	□ Yes	□ No	Liver Disease	□ Yes	□ No	Rheum. Arthritis	□ Yes	□ No
Arthritis	□ Yes	□ No	Eating Disorder	□ Yes	□ No	Migraines	□ Yes	□ No	STD	□ Yes	□ No
Asthma	□ Yes	□ No	Emphysema	□ Yes	□ No	Mononucleosis	□ Yes	□ No	Stroke	□ Yes	□ No
Autoimmune Dis.	□ Yes	□ No	Epilepsy/Seizure	□ Yes	□ No	MS	□ Yes	□ No	Thyroid Disease	□ Yes	□ No
Bleeding Disorder	□ Yes	□ No	Headaches	□ Yes	□ No	Osteoporosis	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Bronchitis	□ Yes	□ No	Heart Disease	□ Yes	□ No	Pacemaker	□ Yes	□ No	Tumors, Growths	□ Yes	□ No
Cancer	□ Yes	□ No	Hepatitis	□ Yes	□ No	Parkinson's	□ Yes	□ No	Ulcers	□ Yes	□ No

For Females Only: Other: _____

Are you pregnant? □ Yes □ No If yes, how many weeks? _____
Birth Control? □ Yes □ No If yes, what kind? _____
Hormone Replacement? □ Yes □ No
Previous pregnancy? □ Yes □ No If yes, when? _____ Resulted in : □ Vaginal Birth □ C-Section

5 Physical & Trauma Information

Please indicate any physical and/or trauma occurences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Retired _____

Work Injuries: □ Yes □ No If yes: _____

Sport Activities: _____

Sport Injuries: □ Yes □ No If yes: _____

Exercise: □ None □ Light □ Moderate □ Heavy _____

Home Injuries: □ Yes □ No If yes: _____

Habits: □ Nicotine □ Alcohol □ Coffee/Caffeine Drinks □ High Stress Level □ None

How Much? _____ How Often? □ Daily □ Weekly □Occasionally

Falls: □ Yes □ No If yes:_____

Head Injuries: □ Yes □ No If yes: _____

Dislocations: □ Yes □ No If yes: _____

Broken Bones: □ Yes □ No If yes: _____

Surgeries: □ Yes □ No If yes: _____

Your Birth Delivery: □ Vaginal □ Cesarean Complications: □ Breech □ Fetal Distress □Placenta Previa □CPD
□ Unknown □ Premature □ Umbilical Cord □Meconium Aspiration □None

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6 Primary Complaint

Please note **ONE** complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

Is this the result of… □ **Auto Accident** □ **Work Injury/Workman's Comp** □ **Other:** _____

Primary Complaint: _____

Please describe the condition: _____

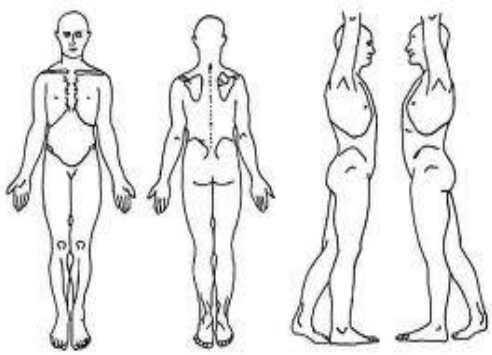
When did your symptoms first appear? _____

Most recent occurrence date: _____

What do you think caused this problem? _____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain…

…at its worst: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

(please circle) …at its best: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain

…at present: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? □ Constantly □ Comes and Goes □ Infrequently □ Daily □ Weekly □ Monthly

Do activities make it worse in the AM or PM? □ AM □ PM □ N/A

Which activities are affected by this? □ Work □ Sleep □ Daily Routine □ Recreation □ N/A □ Other _____

□ Sitting □ Standing □ Walking □ Bending □ Lying Down

Past Treatments: □ Medications □ Surgery □ Physical Therapy □ Chiropractic Care □ None □ Other _____

Were they successful? □ Yes □ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

7 Additional Complaint(s)

Additional Complaint: _____

Please describe the condition: _____

Rate the severity of your pain at the present moment: (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? □ Constantly □ Comes and Goes □ Infrequently □ Daily □ Weekly □ Monthly

Do activities make it worse in the AM or PM? □ AM □ PM □ N/A

Which activities are affected by this? □ Work □ Sleep □ Daily Routine □ Recreation □ N/A □ Other _____

□ Sitting □ Standing □ Walking □ Bending □ Lying Down

Past Treatments: □ Medications □ Surgery □ Physical Therapy □ Chiropractic Care □ None □ Other _____

Were they successful? □ Yes □ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

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8 Payment/Insurance Information:

Who is financially responsible for this account: □ Self or □ Other (Name): _____

If 'Other', what is relationship to patient? _____

**If insured, please provide the desk with a copy of your insurance card(s).

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent to treatment by Center of Chiropractic Neurology, Inc, 3) assign to Center of Chiropractic Neurology, Inc, any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by Center of Chiropractic Neurology, Inc, authorize their payment directly to Center of Chiropractic Neurology, Inc, and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to Center of Chiropractic Neurology, Inc (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to Center of Chiropractic Neurology, Inc releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of Center of Chiropractic Neurology, Inc's Notice of Privacy Practices.

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I *am* personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services, prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually). I also understand that if my account is sent to collections, 35% will be added to the balance owed.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, employer health care provider or attorney in order to process any claim for reimbursement or charges incurred by *me* as a result of professional services rendered and hereby release him/her of any consequences thereof. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total changes for professional services rendered. I agree that a photocopy/facsimile of this agreement shall serve as the original

_____ _____

Printed name of Patient, Guardian or Personal Representative | Signature of Patient, Parent, Guardian or Personal

_____ _____

Relationship | Date

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INFORMED CONSENT

Dear Patient,

Every type of heath care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called "Informed consent".

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, Inc.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the brain stem. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA Vol. 37 No. 2, June 2, 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with *a* single patient stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes disc herniations in both the neck and the back. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move the bones, and ligaments limit the amount of joint movement. Rarely will chiropractic adjustments, traction, massage therapy, etc., tear some muscle or ligament fibers. If this does occur the result is a temporary Increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fracture: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely will chiropractic adjustments "crack" or fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. If a bum occurs, the result is a temporary increase in skin pain. In extreme cases, some blistering of the skin may occur. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problems or complications occur so rarely that it Is impossible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____	_____
Patent's Name Printed	Today's Date
_____	_____
Patient's Signature	Parent/Guardian Signature for Minor
_____	_____
Witness	Today's Date

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date