Wentzville Chiropractic and Acupuncture Center

Joan Brower D.C., Daryl Ridgeway D.C., Xephyr Day D.C., Leah Owens D.C. Jay Hauptman D.C.

Patient Intake Form:

_____ _____/_____/_____

First Name **Middle Initial** **Last Name** **Birthday**

_____

Address **City/State** **Zip Code**

Primary#: (_____) _____-_____ **Mobile#:** (_____) _____-_____

Marital Status: ☐Married ☐Single ☐Other **Gender**: ☐Male ☐Female **Preferred Language**: ☐English ☐Spanish ☐Other

Employment Status: Full Time Part Time Retired Student Other **Employer's #** (_____) _____-_____

Occupation: _____ Whom may we thank for referring you? _____

_____(_____)_____

Emergency Contact Name **Phone #** **Relationship**

Preferred Contact Method: ☐Primary# ☐Mobile# ☐Email Address

Race: ☐ White ☐ Asian ☐ Vietnamese ☐ Samoan ☐ Black/African American ☐Asian Indian
☐Native Hawaiian/Pacific Island ☐ Guamanian or Chamorro ☐ Hispanic ☐ Chinese ☐American
☐Indian/Alaskan Native ☐Filipino ☐ Japanese ☐ Korean ☐Other ☐I choose not to specify

Ethnicity: (Please check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Our Patient Portal gives you access to your records online. Would you like access to your portal?

☐ **Yes** (Please give email address & answer security question) ☐ **No** Thank you

Email Address _____

By providing my email address, I authorize my doctor to contact me via email address provided as well as enable us to send your clinical summaries to you electronically.

Please select a one security question:

☐What is your favorite pet's name? ☐What High School did you attend? ☐What's your mother's maiden name?
☐What is the make of your first car? ☐What is your favorite color? ☐What City were you born?
☐What's your favorite movie? ☐What street did you grow up on? ☐What is your anniversary?

Security Answer (Case Sensitive) _____
Please Print

Insurance Information: Health Insurance Policy **or** Self-Funded

Signature of Patient: _____ Date: _____

Medications: Current medications, including frequency and dosage if known. □ **N/A**

_____

_____

List any known allergies you have had to any medications. □ **N/A**

_____

_____

Do you currently smoke tobacco of any kind? ☐**Yes** ☐**No** ☐**Former Smoker**

If yes, how often do you smoke: ☐**Every day smoker** ☐**Occasional Smoker**

Past Health History: □ N/A

Surgeries: _____
Injuries: _____
Broken Bones: _____
Hospitalizations: _____
Illnesses: _____

Family Medical History: □ N/A

Please list known illness/disease: Cancer, Diabetes, Stroke, RA, Heart Disease
Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Patient Health Questionnaire:

Reason for today's visit-Please describe symptom(s): _____

_____

_____

When did your symptom(s) start: _____

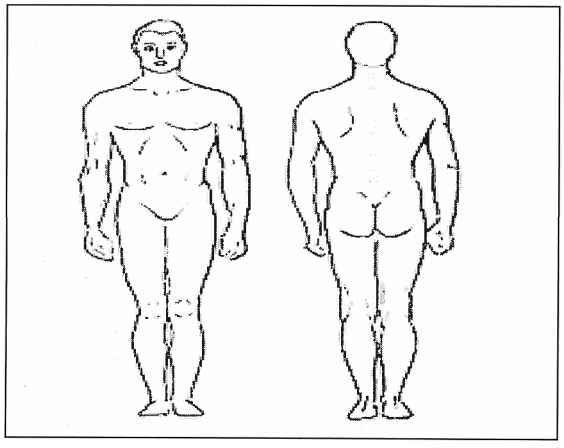
Is this related to your employment? □ Yes □ No Is this related to an auto accident? □ Yes □ No

Please mark the figures using the following keys:

Area of Pain ○ Area of Tightness ● Area of Tenderness ×

*Note the severity of the pain using a 0-10 pain scale

1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain



How often do you experience your symptoms?
Constant Frequently Occasionally Intermittently

Have you seen another Health Care Provider for these symptoms?
□ Yes □ No

If yes, did you have any testing done such as: X-Rays CT Scan MRI Blood Work

Are your symptoms: Improving Worsening Stay the Same

Describe the nature of your symptoms: Sharp Ache Burning Numb Tingling

Please mark all that apply:

General: □ N/A

□ Poor Appetite □ Sweating Easily □ Localized Weakness □ Strong Thirst
□ Cravings □ Fever □ Weight Loss □ Chills
□ Changes of Appetite □ Disturbed Sleep □ Bleeding and Bruising Easily
□ Night Sweats □ Weight Gain □ Poor Balance
□ Insomnia □ Tremors □ Sudden Energy Drop

Skin & Hair: □ N/A

□ Rashes □ Pimples □ Ulcerations □ Dandruff □ Hives □ Hair Loss □ Itching
□ Recent Changes in Moles □ Eczema/Psoriasis □ Changes in Texture of Hair/Skin

Head, Eyes, Ears, Nose & Throat: □ N/A

□ Dizziness □ Eye Pain □ Blurry Vision □ Sinus Problems □ Lip/Tongue Sores
□ Concussions □ Poor Vision □ Cataracts □ Migraines □ Night Blindness
□ Glasses □ Eye Strain □ Color Blindness □ Ringing in Ears □ Nose Bleeds
□ Poor Hearing □ Grinding Teeth □ Headaches □ Ear Aches □ Spots in front of eyes
□ Facial Pain □ Teeth Problems □ Jaw Clicks □ Recurrent Sore Throat □ Eye Strain

Cardiovascular: □ N/A

□ Dizziness □ Phlebitis □ Fainting □ Swelling of Feet □ Low Blood Pressure
□ Blood Clots □ Heart Disease □ Cold Hands/Feet □ Swelling of Hands □ High Blood Pressure
□ Chest Pain □ Difficult Breathing □ Irregular Heartbeat

Respiratory: □ N/A

□ Cough □ Asthma □ Bronchitis □ Excess Phlegm □ Pain with deep inhale
□ Pneumonia □ Coughing up Blood □ Difficult Breathing Laying Down

Gastrointestinal: □ N/A

□ Nausea □ Blood in Stool □ Abdominal Pain □ Black Stools □ Bloating
□ Diarrhea □ Rectal Pain □ Gas □ Constipation □ Gallbladder Surgery
□ Indigestion □ Vomiting □ Bad Breath □ Hemorrhoids □ Chronic laxative Use
□ Belching

Genitourinary: □ N/A

□ Pain in Urination □ Frequent Urination □ Urgency Urination □ Decrease in Flow
□ Unable to Hold Urine □ Impotence □ Blood in Urine □ Kidney Stones
□ Sores on Genitals

Musculoskeletal: □ N/A

□ Neck Pain □ Back Pain □ Hand/Wrist Pain □ Muscle Pains □ Muscle Weakness
□ Shoulder Pain □ Knee Pain □ Foot/Ankle Pain □ Hip Pain

Neuropsychological: □ N/A

□ Seizures □ Poor Memory □ Loss of Temper □ Dizziness/Vertigo □ Loss of Coordination
□ Loss of Balance □ Anxiety □ Areas of Numbness □ Depression □ Easily Susceptible to Stress

Reproductive & Gynecologic: □ N/A

□ Premenstrual Changes □ Heavy Menstrual Flow □ Premature Births □ Menstrual Clots
□ Light Menstrual Flow □ Miscarriages □ Painful Menses □ Irregular Menses
□ Unusual Menses □ Infertility

Age of First Menses_____ Age of Menopause_____ First Day of Last Menses_____

Number of Pregnancies_____ C-Section □ Yes □ No If Yes, how many?_____

Are you on Birth Control Pills? □ Yes □ No If Yes, how long? _____

Other Problems Not Listed: _____

_____

_____

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CONSENT TO CHIROPRACTIC TREATMENT PLAN

THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any healthcare procedures, chiropractic treatments present the risks of complications or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

CHIROPRACTIC MANIPULATION THERAPY

The risk associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. Your doctor may recommend the use of ice packs to reduce the discomfort.

HOT AND COLD THERAPY

Application of a hot or cold pack can cause a local burn. We place a towel underneath the pack to minimize this risk, however if you have very sensitive skin you may experience a reaction. Please inform your doctor if the application is uncomfortable

ULTRASOUND

The therapeutic effect of ultrasound is produced by heat. The risk associated with ultrasound therapy is burning of tissues at the application site. Ultrasound should not be painful. If you experience pain from the treatment please inform your doctor. If you have a metallic implant in the area to be treated, inform your doctor, as the implant concentrates the heat.

ELECTROTHERAPY

The therapeutic electronic current is transmitted to your body via electrodes. A small defect in the electrode coating, not always detected by observation, may concentrate the current, causing a small burn to the skin. If you feel it sting where the electrode is placed, please inform your doctor. Electronic stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform your doctor if the procedure is uncomfortable.

GRASTON SOFT TISSUE TECHNIQUE

A metallic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scared tissue. In some instances this procedure may cause bruising and some reactive swelling. This may be uncomfortable, but is not causing any harm to the patient and this reaction is part of the healing process. Please inform your doctor if you are taking blood thinner medication or if you bruise easily.

LABORATORY TESTS

Laboratory tests, including the collection of a blood sample may be ordered to help diagnosis your condition. Some patients may faint at the site of needles or blood. Patients with delicate veins may experience some bruising at the skin puncture site. In very rare instances the needle can touch a nerve causing pain for a few days or a few weeks.

ACUPUNCTURE TREATMENT

Acupuncture is a generally safe treatment, but may have some side effects including bruising, numbness, tingling, itching, and dizziness or fainting. Extremely rare risks of Acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic using sterile disposable needles and maintains a clean and safe environment.

WATER TABLE THERAPY

Water table therapy uses warm, jetted water to help massage and relax your muscles. May cause redness and/or an itchy sensation to the back. Temperature can get hot, please inform your doctor if it becomes uncomfortable.

INFRARED

Laser light therapy used for intracellular healing. Infrared is great for injuries, rashes, and many other ailments. Infrared can be harmful if used incorrectly near the eyes.

HEAT LAMP THERAPY

Heat lamp therapy increases circulation, loosens fascia, and accelerates the natural healing process, mainly used in conjunction with acupuncture. May cause burning if used too close to the skin.

MASSAGE THERAPY

Massage therapy is used to relax the muscles and tendons. May cause some bruising, temporary muscle soreness, headaches and/or dizziness.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. Please check the appropriate block and sign. I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the clinic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____/_____/_____
(Patient's Name Printed)	**(Patient or Guardian's Signature)**	**(Date Signed)**
_____	_____	_____/_____/_____
(Witness's Name Printed)	**(Witness's Signature)**	**(Date Signed)**

Wentzville Chiropractic and Acupuncture Center

Privacy Notice Acknowledgement

1. Wentzville Chiropractic and Acupuncture Center (WCAC):

   a. Is required by federal law to maintain the privacy of your PHI (Private Health Information) and to provide you with a Privacy Notice detailing the practices legal duties and privacy practices with respect to your PHI..

   b. Is required by state law to maintain a higher level of confidentially with respect to certain portions of your medical information that is provided for under federal law.

   c. Is required to abide by the terms of this privacy notice.

   d. Reserves the right to change the terms of this privacy notice and to make new privacy notice provisions affective for all of your PHI that it maintains. .

   e. Will not retaliate against you for filing a complaint.

2. Authorization: I authorize WCAC to use and or disclose information to the following person(s):

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

☐ **I do not want any medical information released except to myself**

3. Limitations: In addition to the above, the following criteria is restricted to be released:

_____

4. Messages related to PHI: When leaving messages, I give permission to WCAC to leave a detailed message on the requested number. Please √ one or all of the following:

☐ **Home Number** ☐ **Work Number** ☐ **Cell Phone Number**

5. Voluntary Act: WCAC acknowledges that this Authorization is voluntary.

6. Revocation: I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to WCAC. However, any revocation shall not apply to the extent that WCAC has taken action in reliance on this Authorization.

7. Copy of Authorization: If WCAC has requested this Authorization from me, I understand that they will provide me with a copy of this Authorization once signed.

_____ _____

Name (Printed) Signature of Patient and or Guardian

Date: _____/_____/_____

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1023 Main Plaza Drive, Wentzville, MO 63385
(636) 639-8944 or (636) 332-8944

I hereby instruct and allow my elected insurance company to pay any billable charges to any of the listed doctors above to the following address:

1023 Main Plaza Drive
Wentzville, MO 63385

Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you:

C/O Wentzville Chiropractic and Acupuncture Center
1023 Main Plaza Drive
Wentzville, MO 63385

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

I do understand that a quote of benefits is not a guarantee of payment. In an instance where my insurance denies payments for any circumstances the balance becomes my responsibility.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to any insurance company, adjustor, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policyholder_____

Signature of Claimant, if other than Policyholder_____

Witness_____

Date Signed: _____/_____/_____

INFORMATION FORM

DOCTOR NOTES	STAFF NOTES	ABN AT	ABN GA	MISC. NOTES

PATIENT MISSED APPOINTMENT ACKNOWLEDGMENT:

I hereby acknowledge that I will be charged a missed appointment fee if I do not call or cancel within 12 hours of my appointment time.

- **Chiropractic Appointment:** A $25.00 fee for missed appointments
- **Massage Appointment:** A fee of half of the scheduled appointment

X:_____

Date:_____