New Patient Health Information

Patient Name:_____

Address:_____

City: _____ State: _____ Zip Code:_____

Cell Phone: _____ Other Phone: _____

Referred by: _____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided. We will NOT share your email.

Date of Birth: _____/_____/_____ Age: _____ Gender: Male ☐ Female ☐
Marital Status: Single ☐ Married ☐ Other ☐ Height: _____Feet _____Inches Weight: _____
☐ P/T Student ☐ F/T Student ☐ Not Employed ☐ Retired ☐ Employed
Employer:_____
Name and phone of Primary Care Physician:_____

Insurance Company _____
Member # _____Group # _____
Member/Provider/Customer Service phone # _____

Current Medications, including dosage if known. Continue on back if needed. **If none, check here** ☐
1._____ 2. _____
3._____ 4. _____

List any known allergies (medication, environmental, food, etc.) **If none, check here** ☐
1._____ 2. _____
3._____ 4. _____

Please circle which apply:

Caffeine Drinks & Products	Daily	Weekly	Occasionally	Never
Water	Daily	Weekly	Occasionally	Never
Soft Drinks	Daily	Weekly	Occasionally	Never
Fast Food	Daily	Weekly	Occasionally	Never
Exercise	Daily	Weekly	Occasionally	Never

Your Health Profile

Stress can have a major impact on the quality of your health. On a scale of 1-10 with 1 being very minimal stress to 10 being very overwhelming stress, please rate the stress level in your:

Home/Family Life _____ Occupational/Work Life _____ Other_____

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life

Health Concern	Severity 1=Mild 10= Worst	When did this start?	Are symptoms constant or intermittent?	Did the problem begin With an injury? If yes, what type?

Since this problem started , is it: _____Same _____Getting Better _____ Getting Worse
What makes it worse?_____
What, if anything makes it feel better?_____
This interferes with: ___Work ___Leisure ___Sleep ____ Sports Other:_____
List any hospitalizations or major surgeries/date:_____
_____
_____
List any past major accidents or falls:_____
Previous chiropractic care? ☐ No ☐ Yes Condition treated:_____
Doctor's Name & date of last visit _____

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

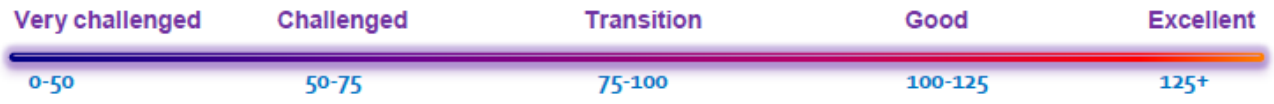
☐ ***I want the Doctor to select the type of care appropriate for my condition.***

☐ **Relief care:** Symptomatic relief of pain or discomfort.

☐ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.

☐ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

As a society we are 50th in the world in health care. We take pride in helping people attain their optimum health and wellness. With that being said we need an honest assessment of your current level of health. So please place an "X" o the scale below, indicating your level of health and wellness at this time. Then place a star (*) on the diagram, showin us the desired location of your health and wellness.



Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:
__Diabetes __Cancer __Heart Disease __Thyroid
__Arthritis __Epilepsy __Eczema __Tested HIV positive

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
__Low Back Pain
__Pain Between the Shoulders
__Neck Pain
__Arm Pain
__Joint Pain/Stiffness
__Walking Problems
__Difficult Chewing/Clicking Jaw

GASTRO-INTESTINAL
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Diarrhea
__Constipation
__Liver Problems
__Gall Bladder Problems
__Weight Trouble
__Abdominal Cramps
__Gas/Bloating After Meals
__Heartburn
__Colitis

NERVOUS SYSTEM
__Nervous
__Numbness
__Dizziness
__Forgetfulness
__Confusion/Depression
__Fainting
__Cold/Tingling Extremities
__Stress

C-V-R
__Chest Pain
__Short Breath
__Blood Pressure Problems
__Heart Problems
__Lung Problems/Congestion
__Ankle Swelling
__Stroke

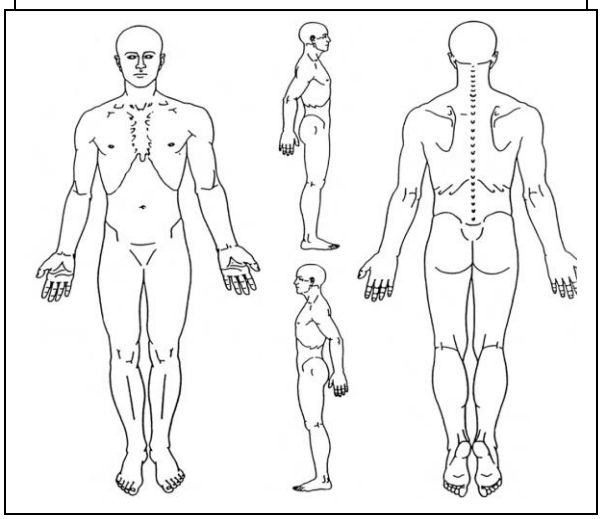
MALE/FEMALE
__Menstrual Irregularity
__Menstrual Cramps
__Other Problems
_____
_____
_____

GENERAL
__Fatigue
__Allergies
__Loss of Sleep
__Fever
__Headaches

GENITO-URINARY
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose

Please outline on the diagram below the area of your discomfort.



Patient Signature:_____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. A copy of the full HIPAA policy is attached for your reading

I, _____, acknowledge receipt of the HIPAA law and subsequent changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____ _____
Patient / Legal Guardian Signature Date

I authorize the following information to be shared with:
Name:_____
Relationship: __ Spouse ___ Friend ____ Parent _____Sibling ____Other:_____
____ Financial/Billing Information _____ Appointment Information
____ Treatment Information _____ Information re Supplement usage

CLINIC FINANCIAL POLICY

FOR CASH PATIENTS:

I understand that all visits will be paid in full at time of service unless other arrangements have been made.

_____ _____ _____

Patient Name – Print Patient Name – Signature Date

FOR INSURANCE PATIENTS:

We do accept assignment of major medical insurance after your coverage has been verified by your insurance carrier. This is a convenience for you and in no way removes your responsibility for the services you receive.

Please initial each statement below:

_____ I understand that I am responsible for any fee schedule fees, co-insurance or co-payment at the time of my office visits.

____I understand if my insurance cannot be verified I must pay for my visits in full until all information has been verified. *(Refunds can only be issued on your account when a credit balance is attained.)*

____I understand that when the insurance company verifies my benefits, it is not a guarantee of payment of claims submitted. I understand all claims submitted by this office are my responsibility and I agree to pay/settle any denied/unpaid claims. If my insurance carrier doesn't reimburse my services within 90 days, I will be billed for my services.

____I understand that my insurance carrier may not authorize the number of visits stated in my policy and that typically maintenance, wellness or supportive level care is not reimbursed by my insurance company.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

Please initial each statement below:

____ I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

____I authorize payment directly to R.T. Alexander P.C. dba Whole Life Health Center, of the health benefits, medical reimbursement from a third party payor and/or government benefits otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.

Signing this form acknowledges you understand and agree to the above statements.

_____ _____ _____

Patient Name – Print Patient Name – Signature Date