

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. _____

Your Health Profile

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: _____

Previous chiropractic care? No Yes Condition treated: _____

Doctor's Name & date of last visit _____

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 |

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

NERVOUS SYSTEM

- Nervous
- Numbness
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Cold/Tingling Extremities
- Stress

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

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

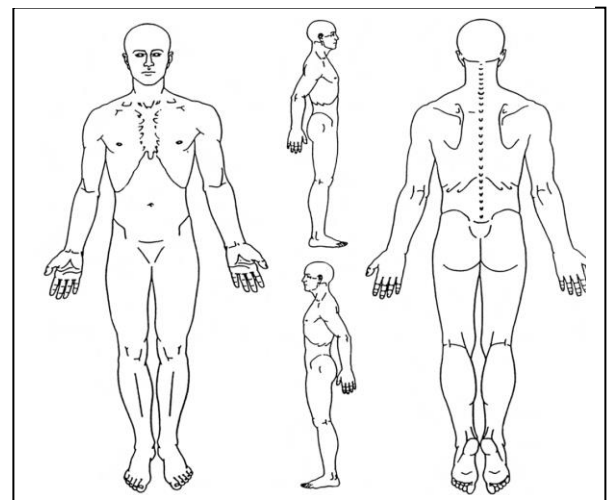
C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Heart Problems
- Lung Problems/Congestion
- Ankle Swelling
- Stroke

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Other Problems

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



Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

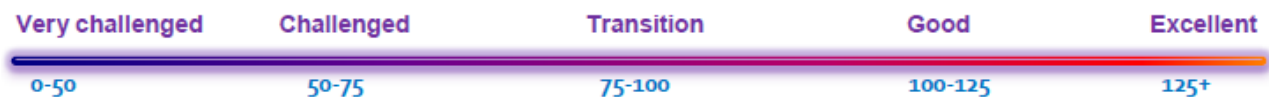
- a. _____
- b. _____
- c. _____

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 _____

Is there anything else it would be important for the doctor to know?

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" on the scale below, indicating your level of health and wellness at this time. Then place a star (*) on the diagram, showing us the desired location of your health and wellness.



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.

Patient Signature: _____ **Date:** _____



HIPPA Notice of Privacy Practices

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

INSURANCE DISCLAIMER

Most insurance companies adhere to the following guidelines:

*"A treatment plan that seeks to **prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition is deemed not medically necessary**"... **Direct quote from Medicare Guidelines, Section 2251.3***

Your insurance can be very beneficial for treating certain injuries and helping you pay for care when you are in a crisis. However, their only responsibility is to get you through the acute stage of an illness or injury. Most insurance companies will limit coverage even in those cases, and will often deny coverage for care.

Insurance companies make decisions about how much and what type of care you need primarily based on statistics without knowing anything about you as a person, your condition or your health. To them, you are just a number.

Please know that we take pride in recommending care based on **your goals, your health, and the results of your tests and scans**, not just what your insurance will cover. We believe good health is "necessary"! We will honor your goals and wishes as to how you wish to use chiropractic services in our office.

I have read and understand the above statements regarding insurance coverage

Patient signature **Date**

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