UPSTON CHIROPRACTIC wellness center

NEW PATIENT PAPERWORK CASE HISTORY:

Date _____

Name _____ Date of Birth _____

Contact Phone # _____ Email: _____

Best Mailing Address: _____City _____State _____Zip_____

Occupation_____ Employer_____

Insurance Co. _____ Social Security # _____

Marital Status: □ S; □ **M**; □ **D**; □ W Spouse's Name _____ # of Children_____

Past Chiropractic Care? □ **Yes**; □ **No** **When?** _____**Dr. Name/Clinic?** _____

Medical Doctor's Name _____ Last Visit _____

What brings you in today? Low Back _____ Mid/Upper Back _____ Neck _____ Other _____

Are your present symptoms due to any of the following?

□ Auto Accident □ Work Injury □ Accident □ Trauma □ Illness

□ Aggravating of a Congenital Problem □ Unknown Factors

Date Symptom Appeared _____ Have you experience this before? _____

Are you in need of any community resources? □ **Yes**; □ **No** _____

Do you feel safe? □ **Yes**; □ **No** _____

Are you currently in an auto accident/work comp case? □ **Yes**; □ **No** _____

Are you now, or have you ever been, disabled? (Service or work) □ **Yes**; □ **No**

If yes, when _____ & how? _____

How Did You Hear About Us? □ Google □ Social Media □ Word of Mouth □ Insurance Co.

If other referral source, how did you hear about us? _____

If Referred by Someone, Name of Patient:_____

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Please check any of the following conditions that pertain to you. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS
____ Decreased Activity
____ Fever
____ Chills
____ Fatigue
____ Night Sweats
____ Loss of Appetite
____ Weight Loss
____ Weight Gain
____ Loss of Energy
____ Uncontrolled Sweat

TROUBLE WITH VISION
____ Blurred Vision
____ Vision Loss
____ Double Vision Loss
____ Eye Pain
____ Glasses/Contacts

STOMACH PROBLEMS
____ Nausea
____ Vomiting
____ Diarrhea
____ Constipation
____ Loss of Bowel Control

IMMUNITY PROBLEMS
____ Enlarged Lymph Nodes
____ Hives
____ Hay Fever
____ Persistent Infections

MENTAL HEALTH PROBLEMS
____ Irritability
____ Depression
____ Disturbed Sleep
____ Suicidal Thoughts
____ Anxiety
____ Nervousness

HEART TROUBLES
____ Chest Pain
____ Palpitations
____ Fainting
____ Shortness of Breath
____ Ankle Swelling

MUSCLE/JOINT PROBLEM
____ Joint Pain
____ Joint Weakness
____ Muscle Weakness

ENDOCRINE PROBLEMS
____ Diabetes
____ Thyroid Disorder

BLEEDING PROBLEMS
____ History of Anemia
____ Abnormal Bleeding
____ Bruising
____ Heat Intolerance
____ Cold Intolerance

TROUBLE URINATING
____ Frequent Urination
____ Urgency
____ Trouble with Stream
____ Erectile Dysfunction
____ Nocturia
____ Burning w/ Urination
____ Losing Control
____ Bowel Dysfunction
____ Sexual Dysfunction
____ Hesitancy

BREATHING PROBLEMS
____ Coughing
____ Wheezing
____ Shortness of Breath

SKIN PROBLEMS
____ Rash
____ Itching
____ Dryness
____ Lesions
____ Open Wound/Infections
____ Hair/Nail Changes

NEUROLOGICAL PROBLEMS
____ Seizures
____ Loss of Feeling
____ Loss of Memory

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Medications

Check all of the following medications that you are currently taking:

____ Anti-Inflammatories
____ Acetaminophen
____ Muscle Relaxants
____ Other Medications
____ Sleeping Aids
____ Anti-Anxiety
____ Medicated Patches
____ Narcotic Pain
____ Anti-Depressants
____ Anticonvulsant

Please list the medications and doses on the lines below:

_____
_____
_____

Surgeries

Check all of the types of surgeries and their dates on the lines below:

____ Lumbar Fusion
____ Posterior Cervical
____ Left Hip
____ Left Shoulder
____ Lumber Decompression/Laminectomy
____ Anterior Cervical
____ Right Hip
____ Right Shoulder
____ Any other surgeries

Please list details of surgery with dates:

_____
_____
_____
_____

Past History

Check on all past and present medical health problems that you may have:

____ Diabetes
____ Ulcer Disease
____ Heart Defects
____ Bleed Easily
____ Lung Disease
____ Kidney Disease
____ Liver Problems
____ Arthritis
____ Stomach Problems
____ High Cholesterol
____ Asthma
____ Other

Please list below:

_____
_____

Please circle what indicates your pain level today on a scale from 0-10 (0 being no pain at all, 10 being excruciating pain:

1 2 3 4 5 6 7 8 9 10

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Family and Social History

Indicate if your parents, sisters or brothers have any of the following problems: (M=mother, F=father, S=sister, B=brother)

____ Arthritis	____ High Blood Pressure	____ High Cholesterol
____ Diabetes	____ Depression	____ Heart Disease
____ Cancer	____ Chronic Pain	____ Other

Please explain below if the answer is other:

_____

_____

Are you working?

□ Yes □ No

What best describes your type of work?

□Not Employed □ Retired

□ Sedentary Duty (Occasional Lifting/carrying small items/10 lbs)

□ Light Duty (Frequent Lifting, 20lbs max, significant walking/standing)

□ Medium Duty (Lifting 50lbs, walking lots)

□ Heavy Duty (Lifting 100lbs, frequent walking/standing)

□ Very Heavy (Lifting Objects over 100lb

Do you drink alcohol?

□ Never □ Occasionally □ Socially □Frequently (More than 3 days per week)

Have you ever had substance abuse treatment?

□ Yes □ No

Have you ever used illegal drugs? (Marijuana, Cocaine, Etc.) ***Marijuana is considered a federally illegal drug***

□ Yes □ No

Have you ever smoked or used tobacco products?

□ Yes, currently □ Yes, past □No **How many per day?** _____

What is education level?

□ Not complete HS	□ High School Graduate	□ GED Diploma/Equivalent
□ Completed Trade School	□ Associate's Degree	□ Completed business school
□ Bachelor's Degree	□Master's Degree	□ Completed medical school
□ Completed Law School	□ PH.D	

I hereby authorize the Doctor to treat my condition as he/she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only.

Patients Signature X_____ Date _____

Guardian Authorizing Care x_____ Date _____

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Welcome to Our Office

Consultation & Exam

To begin today's visit, we will collect some health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests. If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

Report of Findings:

Patients who are examined will receive a report of our findings. If we believe that we can help, we will accept your case. If we believe that you will not respond well to care, we will refer you to another provider.

Treatment Plan:

We may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

Please read the following. If you have any questions please let our office staff know.

Insurance Statement:

1. Your insurance policy is a contract between you, your employer, and your insurance company. All services are provided to you with the understanding that you are responsible for your cost-sharing portion based on your insurance plan. We are not responsible for the pricing the insurance company sets for our services. If you are billing insurance for your visit, we must go by their guidelines. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan, what services are or are not covered. If you would like to know the estimated costs, please inquire with billing staff prior to treatment. Insurance estimates are merely an estimation and are not guaranteed until those services are billed and processed through to your insurance carrier. If denied any services you are subject to our self-pay rate. Some insurance information regarding your benefits is not accessible to us in office, so if you have any questions regarding your policy, benefits or eligibility, we recommend reaching out to the customer service number on the back of your insurance card.

Payment Policy:

1. Payment will be due the day of service unless stated otherwise by billing/office staff. If you prefer to receive billing statements & pay via mail, please communicate with our office.
2. We send billing statements at the beginning of each month. After 3 consecutive billing statements without payment, a $10 statement charge is applied to the account. After 3 consecutive statement charges, Upston Chiropractic Wellness Center reserves the right to send unpaid balances to collections.
3. We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Upston Chiropractic Wellness Center offers flexible payment options, if requested.

I understand the above policies and expectations from today's visit.

_____ _____

Signature of Patient and/or Parent/Guardian of Patient *Date:*

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HIPPA Policy

We want you to know how your patient health information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent stating that you understand and agree with how your records will be used.

1. We may share your health information to treat you, collect payment, run our office, inform you about other services, discuss your case with family with your permission, share information regarding payment balances if someone calls on behalf of you to pay a bill with your permission, share appointment scheduling information with family who requests with your permission, do research based on your medical conditions, include you in care cases, and thank you for referring patients.
2. We may use your health information for health and safety reasons, if need to report to law officials, reporting victims of abuse and other negligence, court hearings and filings, reporting to workers compensation.
3. You have the right to request a copy of your health record, request a list of whom we share your health information with, ask us to limit the information we share, request confidential communications, and amend your protected health information.
4. If choosing to amend and/or limit who we share that protected health information with, you must provide in writing stating who you wish us not to disclose your information with. All requests will be kept on file and will only be terminated with written consent.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received the copy of the notice of privacy practices or had an opportunity to receive the copy.
- The doctor(s) may use my confidential health information in the manner previously described.

_____ _____

Signature Date

Child/Minor (under 18)

I, _____ have read and understand how my Sons/Daughters patient health information will be used and I agree to these policies and procedures.

_____ _____

Parent/Guardian Signature Date

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Blake Upston, D.C, Dr. Kali C. Edwards, DC and/or other licensed Physicians of Chiropractic who may treat me now or in the future at the office of Upston Chiropractic Wellness Center. I have had an opportunity to discuss with Dr. Blake C. Upston DC, Dr. Kali C. Edwards DC and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, sprains/Strain, dizziness, increased soreness, and headache. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be Completed by Patient:

_____ (Print)

_____ (Signature)

_____ (Date)

To be Completed by Parent/Guardian (Under 18)

_____ (Print)

_____ (Signature)

_____ (Date)

This form should be maintained in the patient's health record