Today's Date: _____

Last Name: _____ First Name: _____ Middle_____

Main Phone # (_____) _____ **EMAIL*:**_____
We do NOT give, rent, or sell your information to anyone, EVER.* **We send out special announcements and life hacks to help you stay well.

Street Address: _____ (apt #)_____

City: _____ State: _____ Zip:_____

Date of Birth:_____ Gender (m) (f) *(optional) Weight:*_____ *Height:*_____

What kind of work do you do/job title:_____

□Deskwork □Lots of standing □Heavy lifting □Almost all at a computer □ Lots of driving □Climbing
□ Lots of walking □lots of bending □lots of reaching □kneeling □Repetitive hand/shoulder work

How did you hear about Natural BodyWorks?

□Referral (who?) _____ _____ □Internet search □ Insurance directory □other:_____

*I am here for (**or interested in** the following services)*

□ Chiropractic* □ Acupuncture □ Dry Needling

Other add-ons include Trigger point, Cupping, and Electrical Therapy

☑ Today's fee is $139 for treatment and evaluation. OTHER FEES MAY APPLY)

(We accept cash, check, debit, FSA, HSA, credit card, and Venmo)

This visit/treatment is related to a motor vehicle or work-related injury*. ***Initial____ (There's more paperwork!)***

☑ We charge for copies of records $18.53 for up to 10 pages, 85 cents for each additional page.
☑ We charge for ANY reports, opinions, or other statements other than billing receipts. $325.00
☑ We do not work on contingency; you may prepay, and a receipt will be printed for you to get reimbursement.
☑ *Med-pay on Auto insurance **may be** accepted. You are responsible for any unpaid balance by your insurance or legal case, we do not work on Lien, unless prior agreement is made.

Complete health information next…

General health info:

Before we decide which services are best for you, please let us know more about you…Mark any that apply, please feel free to explain any answers below. **CONFIDENTIAL**

What are you here to work on? Please be as specific as possible; (WHY ARE YOU HERE) _____
._____.

□ Do you have high blood pressure?

□ Do you have breathing problems; asthma, bronchitis, COPD?

□ Do you have allergies? □ Food or □ airborne…

□ Do you have any heart issues? Murmurs, palpitations, PVCs, etc.

□ Do you take any over the counter medications daily? Aspirin, Tylenol, etc.

□ Are you on blood thinners or take fish oil/ omega oils?
□ Do you take any prescription medications?
_____

□ Do you have cholesterol problems?

□ Do you smoke? Vape?

□ Unexpected weight changes in last 6 months:
□ Gain _____ □ Loss _____

□ Do you get upset easily? □ worry, □ frustration, □ Sadness □ anger.

□ Do you often have constipation? Slow bowels, etc.
□ Do you have other digestive issues: Indigestion, Crohn's, Ulcerative Colitis, IBS, etc.
□ Do you have a nervous stomach? Including ulcers, GERD, IBS, reflux, etc.
□ Do you have diabetes?

□ Do you have frequent thirst or urination?

□ Do you have any numbness?

□ Do you have any tingling?

□ Do you have achy muscles?

□ Do you have dizziness? Nausea? The spins?

□ Do you have any shooting pain?

□ Fatigue □Beginning of day □ End of day □all day

□ Have you been diagnosed with cancer? (Ever?)

□ Do you have a disc injury, □ Cervical (Neck), □ Lumbar (lower back)

□ Do you have osteoarthritis, rheumatoid arthritis, SLE, or other joint disease

□ Do you have anxiety? □Depression/ □ADD/ADHD
□ Bipolar □ Schizophrenia disorders □other.
□ Diseases you know you have but not 'officially' diagnosed? _____

□ Fibromyalgia?

□ Neurological issues. Numbness, tingling, etc.

□ Do you have any pain that wakes you up at night?

□ Do you have any medical problems not diagnosed but are worried about?

Chiropractic is interested in treating neurological dysfunction that can affect the organs in the body. Please mark any of these you experience…

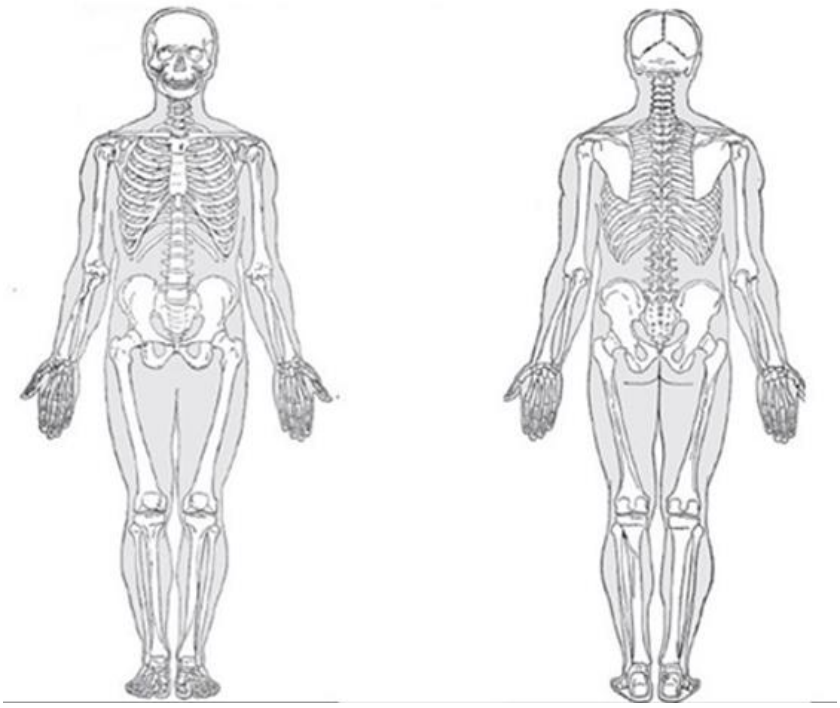
□ Missing parts (surgeries where something was removed) Please mark where/what.
□ Extra parts (surgeries with implants) Please mark where/what.
□ Nuts and bolts or metal plates **please mark where they are.**

Where do you hurt now? (The most, or area you would like to focus on)

_____
When did it begin? _____
What makes it better? _____
What makes it worse? _____
How do you describe the pain? _____
Does the pain travel? _____
On a scale of 1 – 10, ten being the worst pain imaginable, what is your pain NOW?
What is your pain at night?
What is your pain when you wake up?

How often do you have pain? (Circle One) Occasionally, Frequently, Often, Constantly

mark where you have pain on the diagram below.



Acknowledgement and Acceptance of Treatment (the fine print…)

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. In the therapies practiced at Natural BodyWorks there are some risks to treatment, including, but not limited to, muscle soreness or spasms for short periods of time, dizziness, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, and on extremely rare occasions; sprains, fractures, disc injuries, strokes, dislocations, bruising, hematomas, and the possibility of a small amount of bleeding (acupuncture only).

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I will rely on the doctor to exercise judgment for the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. I understand and have been informed that I have the right to and are encouraged to get a second opinion if I have concerns as to the nature of my symptoms and treatment options. I understand that some procedures used may be considered 'unproven'. Please contact us immediately with any increase or change in your condition after treatments.

I understand that my information is strictly private and protected here under the Health Insurance Portability and Accountability Act or HIPAA. It may only be released by this signature or under subpoena. *Details are available upon request. I also verify ALL information as true and complete as remembered or understand as complete. Any information not provided cannot be used to render an effective treatment plan and may delay recovery, referral, and relief or may render any treatment ineffective. By signing below, you are also allowing us to use your contact information for advertising, emails, tweets, texts, and other forms of contact. No information is provided to any other party.*

1. Services provided in this office are payable the day services are rendered unless other agreements have been made prior to seeing the doctor. Patients are personally responsible for all charges. We do not offer refunds.

2. There will be a $50.00 charge for returned checks due to nonsufficient funds (NSF). After two NSFs, checks can no longer be accepted as a method of payment.

3. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.

4. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me – not between my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual and customary documents to assist in collecting from my insurance company. Insurance companies may disallow certain procedures without our knowledge. You agree to pay for any services received, <u>regardless of insurance coverage</u>.

Signed: _____ Date_____

We are not able to evaluate or treat you until this entire documentation is complete and signed.