

Adult New Patient Documentation

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712 (828)884-5557
drnewton@chiropracticalways.com

Today's Date: _____ Can we thank someone for referring you? _____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City: _____ State/Zip: _____
Home phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____
SS#: _____ E-mail address: _____
Employer: _____ Occupation: _____
Marital Status: S M D W L/W Spouse/Partner's name: _____
Ages of Children: _____
Date you last saw a Chiropractor: _____ Dr. _____

PATIENT HISTORY

How long has it been since you really felt good? _____

MAJOR COMPLAINT: _____

How long have you had this condition? _____ Start date: _____

Have you had this before? () No () Yes When? _____

Was the injury related to: () Work accident () Auto accident? () Other _____

Is your problem getting worse? () Yes () No () Constant () Comes and Goes

What makes the problem worse? _____

Have you lost time from work from this condition? () No () Yes How much lost work? _____

Is this Problem interfering with your: () sleep () daily routine () other _____

What do you believe to be the cause of your problem? _____

Your expectations from chiropractic care (Check all that apply)

- () Relief of a symptom or problem () Relief and Prevention of a symptom or problem
() Healthier spine and nervous system () Optimal health on all levels

Please mark (0) for past conditions & (X) for present conditions & (F) if condition runs in the family

SECTION I

___ Fractured Bones	___ Auto Accidents	___ Other Accidents/Falls
___ Knocked Unconscious	___ a. 0-1 years ago	___ Back Curvature
___ Emotional Upsets	___ b. 1-5 years ago	___ Arthritis
___ Diabetes	___ c. more than 5 years	___ Swollen or Painful Joints
___ Convulsions/Epilepsy	___ Skin Problems	___ Itching
___ Bruise Easily	___ Cancer	___ Frequent Colds/Flu

SECTION II

___ Nervousness	___ Tension	___ Irritable
___ Anemia	___ Excess Sweating	___ Tremors
___ Eyes sensitive to light	___ Allergies	___ Sinus Problems
___ Light headed upon Arising	___ Under Stress	___ Crave sweets/Salt
___ Eating Disorders		

SECTION III

___ Trouble Sleeping	___ Trouble Concentrating	___ Loss of Memory
___ Learning Disability	___ Mistake Sidedness (L to R)	___ Stutter
___ Dyslexia	___ Mood Changes	___ Lose Temper Easily

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SECTION IV

- | | | |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Stiff Neck/Neck Pain (R,L) | <input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers (R,L) |
| <input type="checkbox"/> Jaw Pain, click (TMJ),(R,L) | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Tired Head & Shoulders | <input type="checkbox"/> Difficulty with standing, sitting, walking, bending, twisting, housework | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lower-back pain (R,L) |
| <input type="checkbox"/> Ringing in Ears (R,L) | <input type="checkbox"/> Mid-back pain, stiffness (R,L) | <input type="checkbox"/> Foot Trouble (R,L) |
| <input type="checkbox"/> Upper-back Pain, stiffness (R,L) | <input type="checkbox"/> Hip Pain (R,L) | |
| <input type="checkbox"/> Numbness, tingling or pain in buttocks, thighs, legs, feet or toes | <input type="checkbox"/> Pain with cough, sneeze or strain at stools | |

SECTION V

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Gall Bladder Problems | | |

Section VI

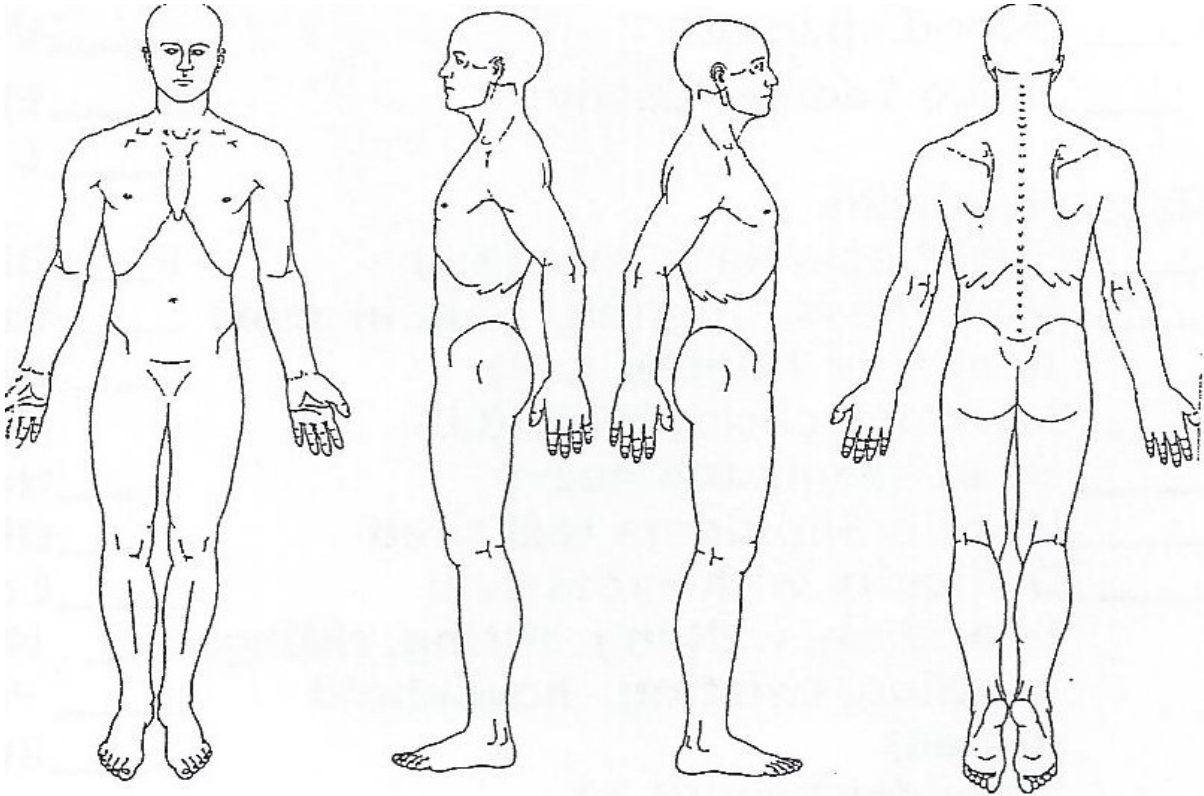
- | | | |
|---|--|---|
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Belching, bloated after meal |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Colon Problems |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Impotence |

SECTION VII

- | | | |
|--|---|---|
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Discharge | <input type="checkbox"/> Menstrual Issues/PMS |
| <input type="checkbox"/> Breast lumps, soreness, discharge | <input type="checkbox"/> Pregnant (now) | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS/ARC | _____ | _____ |

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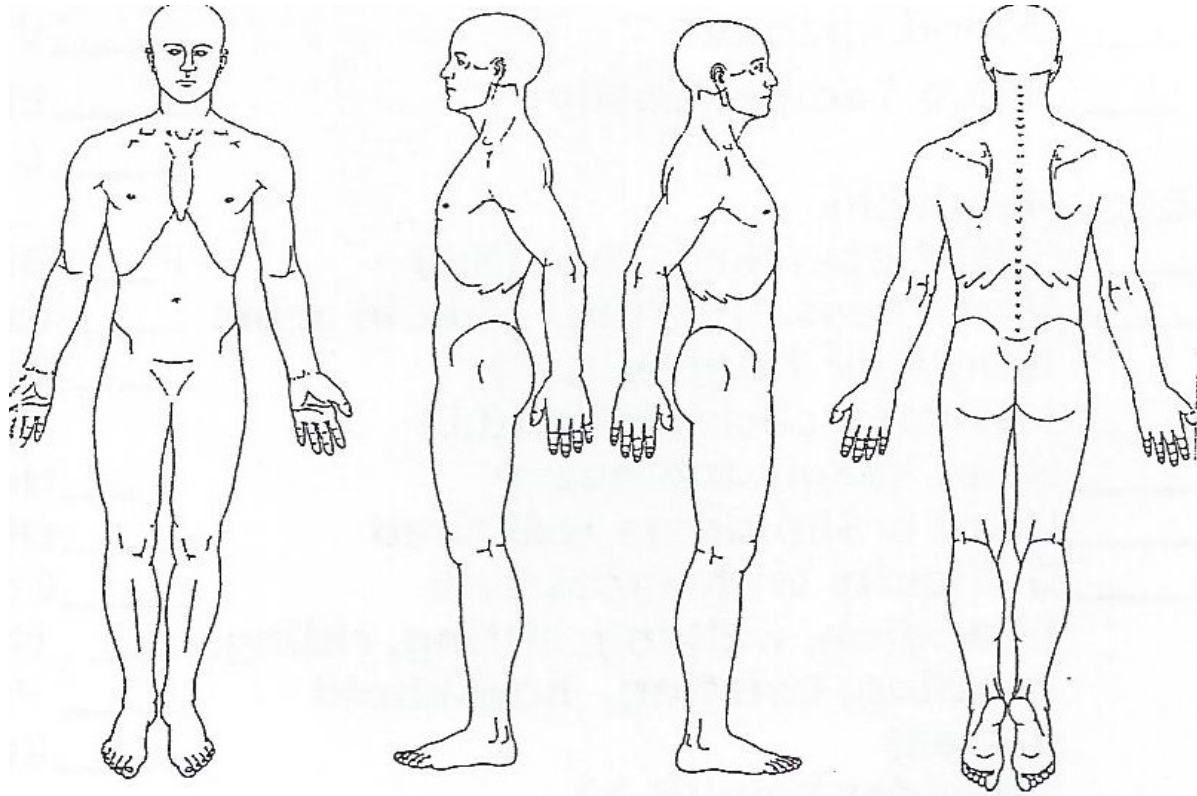
What surgeries have you had & WHEN? Please list as S1, S2, S3 on the diagram.

What broken bones have you had & WHEN? List as F1, F2, F3 on the diagram.

What injuries from accidents have you had when? List as A1, A2, A3 on the diagram.

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Locate the tension felt in your body by placing T1, T2, T3 on the diagram below.
Locate the areas of restriction by placing R1, R2, R3 on the diagram which follows.
Locate the areas of pain in your body using P1, P2, P3 (Rate the pain on a scale of 1-10, 1=low, 10= high)
on the diagram below. Indicate if the pain is dull, sharp, constant, on and off, when standing, only when
sitting, etc.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

Signature Date: _____

Patient Name _____

Patient Address: _____

Patient Signature: _____

Guardian/Spouse/Parent Name _____ Signature: _____

Information Taken by: _____

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PAYMENTS and INSURANCE VERIFICATION

Insurance is a contract between the insured, the patient, and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

Please have the following information when calling your insurance company:

1. Insurance company's phone number (on the back of your card): _____
2. Policy holders name (if different from patient): _____

Please obtain and verify the following information. They cannot process your claim without this information.

1. Ask for the name of the person giving you this information:
2. Ask if you have chiropractic coverage for out of network providers. If yes, please continue to verify type and amount of coverage.
3. What is the yearly deductible: _____ Per Person: _____ Per Family: _____
4. How much of the deductible has been met this year? _____
5. What is the co-pay: _____
6. Is there a limit to the number of visits or a \$ amount? ____ If yes, how many visits are allowed and/or what is the \$ limit?: _____
7. Are services limited by Medical Necessity? _____
8. Does your plan cover Wellness or Maintenance Care? _____
9. What is the effective date of the policy? _____
10. Policy holder's employer: _____ ID# _____ Group # (if applicable): _____

a. Name and address of the insurance office where the claims are sent:

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.

SUBMITTING BILLS TO YOUR INSURANCE COMPANY

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with itemized monthly statements for you to submit. Please indicate below the type of statement you may need.

- Flex Plan or Health Savings Account Statement
- Insurance Statement

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INSURANCE PROCEDURES:

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. (See reverse for details)

If you have determined that your insurance will cover your care in our office, we will supply you with all of the paperwork necessary for you to get reimbursed quickly. We will give you a statement at the end of your first week and then once a month after that. When you send in your statements, your insurance company will reimburse you directly. They are responsible to you, as the subscriber, not to us, the provider.

AUTO ACCIDENTS AND WORK-RELATED INJURIES:

If your insurance company requires direct billing from us, we will supply the necessary information for them to remit payment to our office on your behalf. Please understand that you are responsible to pay for all services until we receive approval and/or payment from the insurance carrier. Once payment is verified you will be reimbursed accordingly. You are still responsible for deductibles, co-payments, and any other balances not reimbursed by the insurer.

NOTE: You must verify the type and amount of coverage before we can submit claims on your behalf. Until we receive this information and verification and/or payment from the insurance company, your account will be on a cash basis.

I have read, understand and agree to complete all forms necessary to allow ChiropracticAlways to assist me with insurance reimbursement. I understand that I am personally responsible for all services received should my insurance fail to remit payment. I agree to pay for all services I receive here on the date they are provided.

Date: _____

Patient Name _____

Patient Address: _____

Patient Signature: _____

Guardian/Spouse/Parent Name _____ Signature: _____

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CONSENT FORM

- A copy of ChiropracticAlways' "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on www.chiropracticalways.com website.
- I consent to receive communication from ChiropracticAlways in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.
- I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.
- It has been explained verbally and in writing that Chiropractic can sometimes have side effects or risk of ataxia, bruising, thermal injury, dislocation/subluxation, dizziness, "drop attacks", fracture, mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to the brain, visual disturbances, pain, tinnitus, hallucination or death. While none of these complications have ever occurred under my care, should this happen in your case, for your protection, you would be referred immediately to another physician or appropriate health care provider for surgery or other "standards of care" treatment.
- On rare occasions side effects of massage can include bruising, inflammation, swelling and pain.
- I acknowledge that the risks of Chiropractic treatment have been explained to me verbally and in writing, I assume full responsibility for these risks.
- Should I choose detoxification as a treatment with Dr. Newton, I recognize that as my body releases poisons, there may be associated memory which comes to the surface (somatic-visceral) and I agree to obtain professional council upon the recommendation of Dr. Newton.
- I understand that detoxification can sometimes have side effects or risk of nausea, vomiting, diarrhea, memory recall and fainting.
- I fully understand the above Consent Form Information. I fully understand the risks and limitations of Chiropractic Care, Massage and Detoxification. I understand and fully consent to treatment with Dr. Newton for Chiropractic, Massage and Detoxification when it has been determined the care is needed. No guarantee of assurance of results has been made. I agree and intend this consent form to cover the procedures recommended in my case including the use of Chiropractic Care, Evaluation, Diagnosis, Adjustments, massage, Detoxification Methods, Manipulations, and treatment for any future conditions for which I seek treatment.

Date: _____

Patient Name _____

Patient Address: _____

Patient Signature: _____

Guardian/Spouse/Parent Name _____ Signature: _____

Witness: _____

Welcome to ChiropracticAlways!