SEELEY LAKE CHIROPRACTIC

PERSONAL INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)

PREFERRED NAME

ADDRESS

CITY STATE ZIP CODE

PHONE

EMAIL

SOCIAL SECURITY NUMBER BIRTHDAY AGE

SEX: ○ MALE ○ FEMALE

MARITAL STATUS: ○ MARRIED ○ SINGLE ○ OTHER ○ MINOR

EMPLOYER/SCHOOL

OCCUPATION

SPOUSE'S NAME

SPOUSE'S EMPLOYER / OCCUPATION

IN CASE OF EMERGENCY, CONTACT

NAME RELATIONSHIP

CONTACT NUMBER

PREFERED FORM OF COMMUNICATION: ○ TEXT ○ EMAIL ○ PHONE

Who may we thank for referring you?

Have you been adjusted by a Chiropractor before? ○ YES ○ NO

If yes, whom? _____ Last adjustment _____

Reason for previous visits _____

HOW CAN WE SERVE YOU TODAY?

PLEASE CHECK THE TYPE OF CARE DESIRED SO THAT WE MAY BE GUIDED BY YOUR WISHES WHENEVER POSSIBLE.

○ COMPREHENSIVE CARE
Care aligned with current goals and needs to relieve current symptoms, correct the cause and proactively seek to maintain progress for long term well-being

○ CORRECTIVE CARE
Relieve the current symptoms and work towards correcting the cause

○ SUPPORTIVE CARE
(Skip to page 3) In the absence of pain or discomfort, I seek to have care provided to ensure my Central Nervous System is properly adapting/functioning at 100%

○ RELIEF CARE
Symptomatic relief of pain or discomfort

CONCERNS & IMPACT

SEELEY LAKE CHIROPRACTIC

PRIMARY CONCERN

The primary concern that prompted me to seek care today is:

_____

_____

HOW OFTEN DOES THIS OCCUR?

○ Constant ○ Intermittent ○ ___ % of the day

WHAT DOES IT FEEL LIKE?

○ Numbness ○ Tingling ○ Stiffness ○ Dull
○ Aching ○ Cramping ○ Nagging ○ Sharp
○ Shooting ○ Burning ○ Throbbing ○ Stabbing
○ Swelling ○ Other_____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

○ An accident or injury ○ Work ○ Auto
○ A worsening long-term problem
○ Other _____

PRIOR INTERVENCTIONS

(What have you done to relieve the symptoms?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

SECONDARY CONCERN

The secondary concern that prompted me to seek care today:

_____

_____

HOW OFTEN DOES THIS OCCUR?

○ Constant ○ Intermittent ○ ___ % of the day

WHAT DOES IT FEEL LIKE?

○ Numbness ○ Tingling ○ Stiffness ○ Dull
○ Aching ○ Cramping ○ Nagging ○ Sharp
○ Shooting ○ Burning ○ Throbbing ○ Stabbing
○ Swelling ○ Other_____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

○ An accident or injury ○ Work ○ Auto
○ A worsening long-term problem
○ Other _____

PRIOR INTERVENCTIONS

(What have you done to relieve the symptoms?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

ADDITIONAL CONCERN

The additional concern that prompted me to seek care today:

_____

_____

HOW OFTEN DOES THIS OCCUR?

○ Constant ○ Intermittent ○ ___ % of the day

WHAT DOES IT FEEL LIKE?

○ Numbness ○ Tingling ○ Stiffness ○ Dull
○ Aching ○ Cramping ○ Nagging ○ Sharp
○ Shooting ○ Burning ○ Throbbing ○ Stabbing
○ Swelling ○ Other_____

Does it radiate? If so, where? _____

AND IS THE RESULT OF:

○ An accident or injury ○ Work ○ Auto
○ A worsening long-term problem
○ Other _____

PRIOR INTERVENCTIONS

(What have you done to relieve the symptoms?)

_____

What aggravates the concern?

_____

What relieves the concern?

_____

If this concern went without being taken care of, how do you think it would affect you? _____

IMPACT OF YOUR SYMPTOMS

(How do these concerns currently interfere with your life and ability to function?)

	No Effect	Mild	Moderate	Severe
Sitting	○	○	○	○
Rising out of a chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild	Moderate	Severe
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○
Duties of employment	○	○	○	○

Patient Name: _____ **Patient Number:** _____

PATIENT HISTORY

SEELEY LAKE CHIROPRACTIC

HEALTH HABITS

Alcohol	O Daily	O Weekly	How much?
Coffee	O Daily	O Weekly	How much?
Tobacco	O Daily	O Weekly	How much?
Exercise	O Daily	O Weekly	How much?
Pain relievers	O Daily	O Weekly	How much?
Soft drinks	O Daily	O Weekly	How much?

Vaccinated? O Yes O No
Mercury fillings? O Yes O No
Recreational drugs? O Yes O No
Do you wear heel/sole lifts or arch supports?
O Yes O No
How much sleep do you average per night?____Hours

What is the type and approximate age of your mattress?

What is your preferred sleeping position?

Describe your typical eating habits:
O Skip breakfast O Two meals a day
O Three meals a day O Snacking between meals

ALLERGIES

MEDS, VITAMINS & SUPPLEMENTS

STRESS LEVELS

Prayer or meditation? O Yes O No

Job pressure/stress? O Yes O No

Financial peace? O Yes O No

What is the major stressor in your life?

In addition to the main reason for your visit today, what additional health goals do you have?

INJURIES & ILLNESS

HAVE YOU EVER...

O Had a fracture or broken bone
O Had a spine or nerve disorder
O Been knocked unconscious
O Been injured in an accident
- If job related, have you made a report of your accident to your employer? O No O Yes

If yes, please explain

Have you had COVID? O No O Yes
If yes, when/date(s)
Was it confirmed by a test? O No O Yes
Have you received any COVID vaccine(s)? O No O Yes
If yes, which manufacturer?
When/date(s)

ILLNESS, PAST OPERATIONS & HOSPITALIZATIONS

FOR WOMEN ONLY

How many children do you have? _____ Are you nursing? O No O Yes Are you on birth control? O No O Yes
Do you have irregular cycles? O No O Yes Do you experience painful periods? O No O Yes Do you have breast implants? O No O Yes
Are you currently pregnant? O No O Yes, I am due OB/GYN / Midwife
Number of past pregnancies
Concerns / complications with this pregnancy?

O I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
Date of last menstrual period (MM/DD/YYYY): Initial here

Patient Name: **Patient Number:**

REVIEW OF SYSTEMS

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Mark the circle beside any condition that you've had, currently have or have family history of.

MUSCULOSKELETAL

Osteoporosis	O Had	O Have	O Family History
Arthritis	O Had	O Have	O Family History
Scoliosis	O Had	O Have	O Family History
Neck pain	O Had	O Have	O Family History
Back problems	O Had	O Have	O Family History
Hip disorders	O Had	O Have	O Family History
Knee injuries	O Had	O Have	O Family History
Foot/ankle pain	O Had	O Have	O Family History
Shoulder problems	O Had	O Have	O Family History
Elbow/wrist pain	O Had	O Have	O Family History
TMJ issues	O Had	O Have	O Family History
Poor posture	O Had	O Have	O Family History

SKIN

Skin cancer	O Had	O Have	O Family History
Psoriasis	O Had	O Have	O Family History
Eczema	O Had	O Have	O Family History
Acne	O Had	O Have	O Family History
Hair loss	O Had	O Have	O Family History
Rash	O Had	O Have	O Family History

GENITOURINARY

Kidney stones	O Had	O Have	O Family History
Infertility	O Had	O Have	O Family History
Bedwetting	O Had	O Have	O Family History
Prostate issues	O Had	O Have	O Family History
Erectile dysfunction	O Had	O Have	O Family History
PMS symptoms	O Had	O Have	O Family History

SENSORY

Blurred vision	O Had	O Have	O Family History
Ringing in ears	O Had	O Have	O Family History
Hearing loss	O Had	O Have	O Family History
Chronic ear infection	O Had	O Have	O Family History
Loss of smell	O Had	O Have	O Family History
Loss of taste	O Had	O Have	O Family History

DIGESTIVE

Ulcer	O Had	O Have	O Family History
Food sensitivites	O Had	O Have	O Family History
Food allergies	O Had	O Have	O Family History
Hearburn	O Had	O Have	O Family History
Constipation	O Had	O Have	O Family History
Diarrhea	O Had	O Have	O Family History

CARDIOVASCULAR

High Blood Pressure	O Had	O Have	O Family History
Low Blood Pressure	O Had	O Have	O Family History
High Cholesterol	O Had	O Have	O Family History
Poor Circulation	O Had	O Have	O Family History
Angina	O Had	O Have	O Family History
Excessive bruising	O Had	O Have	O Family History

RESPIRATORY

Asthma	O Had	O Have	O Family History
Apnea	O Had	O Have	O Family History
Emphysema	O Had	O Have	O Family History
Hay fever	O Had	O Have	O Family History
Shortness of breath	O Had	O Have	O Family History
Pneumonia	O Had	O Have	O Family History

ENDOCRINE

Thyroid issues	O Had	O Have	O Family History
Immune disorders	O Had	O Have	O Family History
Hypoglycemia	O Had	O Have	O Family History
Frequent infection	O Had	O Have	O Family History
Swollen glands	O Had	O Have	O Family History
Low energy	O Had	O Have	O Family History

CONSTITUTIONAL

Fainting	O Had	O Have	O Family History
Low libido	O Had	O Have	O Family History
Poor appetite	O Had	O Have	O Family History
Fatique	O Had	O Have	O Family History
Sudden weight loss	O Had	O Have	O Family History
Sudden weight gain	O Had	O Have	O Family History
Weakness	O Had	O Have	O Family History

NEUROLOGICAL

Anxiety	O Had	O Have	O Family History
Depression	O Had	O Have	O Family History
Headache	O Had	O Have	O Family History
Dizziness	O Had	O Have	O Family History
Pins and needles	O Had	O Have	O Family History
Numbness	O Had	O Have	O Family History
Migraines	O Had	O Have	O Family History

Is there anything else you would like us to know about you or your family's health and overall goals?

Patient Name: _____ Patient Number: _____

ACKNOWLEDGMENTS

SEELEY LAKE CHIROPRACTIC

OUR EXPERIENCE HAS SHOWN THAT IT IS BENEFICIAL TO HAVE A GREAT UNDERSTANDING WITH OUR CLIENTS AS TO WHAT CHIROPRACTIC IS, THE VALUES OUR OFFICE HOLDS AND FEES FOR SERVICES. PLEASE READ EACH SECTION, INITIAL AND SIGN AND DATE AT THE BOTTOM.

WHAT IS CHIROPRACTIC CARE?

Chiropractic is the science which concerns itself with the relationship between the structures (primarily the spine) and function (primarily the central nervous system hereby referred to as the CNS) and how this relationship can affect the restoration and preservations of health. Spinal subluxation is a disturbance to the CNS and is a condition where one or more vertebra in the spine is misaligned and/ or does not move properly causing interference and/ or irritation to the CNS. The primary goal of care is by application of a precise movement and/or gentle force into the spine to reduce and/or correct vertebral subluxation(s). There are several different methods or techniques by which the chiropractic adjustment can be delivered, typically delivered by hand or mechanical instrument (activator).

At Seeley Lake Chiropractic (SLC), we do not diagnose or treat any disease other than vertebral subluxation and the doctor/ office will not be held responsible for any pre-existing medical conditions. To the best of my ability and knowledge, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Initial here _____

CONSENT TO CARE

While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic care, like other forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/ strain, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per million to one per two million, have been associated with chiropractic adjustments. Chiropractic is a separate and distinct healing art form and does not proclaim to cure any named disease or entity. We strive to provide you with the very best care and if the results are not acceptable, we will refer you to another provider who we feel can further assist you. Initial here _____

Please indicate any procedure that you DO NOT CONSENT to as part of the analysis, examination and treatment:
O Spinal Adjustment O Range of Moton Testing O Muscle Strength Testing O Palpation
O Mechanical Instrument (activator) O Orthopedic testing O Postural Analysis Testing
O Hot/Cold Therapy O Neurological Testing O Cupping O Flexion Distraction

Notes: _____

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at SLC have been explained to me to my satisfaction. My initials are acknowledgement that I have weighed the risks involved in on-going care and have decided that it is in my best interest to proceed with the recommended treatment. Initial here _____

PRIVACY POLICY

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open at times. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and team members. This environment is used for ongoing care and is NOT the setting used for taking patient histories, performing examinations, or presenting report of findings- these procedures are completed in a private confidential setting.

This office is required to notify you that by law, we must maintain the privacy and confidentiality of your personal health information. You may request a copy of the Privacy Policy and understand it describes how your personal health information is protected and released on your behalf for seeking reimbursement from any involved third parties. Initial here _____

Whom do you authorize we discuss your care with _____

Patient Name: _____ **Patient Number:** _____

ACKNOWLEDGMENTS (CONTINUED)

SEELEY LAKE CHIROPRACTIC

VALUES

Our goal is to provide you with excellent customer service and care. To attain the level of achievement we both desire, care must be followed and therefore we need your commitment as well. We value your time and work diligently to serve you in a timely manner. Please keep your appointments as scheduled or call/text within 24 hours to request changes. Patients who do not show up for a scheduled appointment without prior contact may be charged a "No Show" fee of $60. If on a care plan and a no show occurs, 1st occurrence will be forgiven, 2nd occurrence charged at 50% of the appointment amount, 3rd no show charged 100% of the appointment amount.
Initial here _____

I grant permission to be called and/or text to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care in this office. Initial here _____

FEE FOR SERVICES

We may chose to submit insurance claims for you on your behalf. In that event, you are responsible for any co-pays, deductible amounts not yet met, or uncovered services by your insurance carrier. Any quoted benefits by your insurance carrier or our team member is NOT a guarantee for reimbursement and ultimately, you are responsible for payment. The actual coverage and patient responsibility may only be determined by the Explanation of Benefits statement received from your insurance company after billing, which may take several weeks; we ask that you pay the estimated amount and once the EOB is received you will be notified of any credits and or additional amount due.

Payment for appointments are due at the time of service including first visit fees estimated to not be not covered by a insurance policy, co-payment or self-pay payment (cash). Late payment may be subject to a 18% annual finance charge which will be added to your monthly statement.

GOOD FAITH ESTIMATE BASED ON THE INFORMATION AVAILABLE AT THIS TIME:

	TOTAL	PATIENT RESPONSIBILTY	ESTIMATED INSURANCE COVERAGE
• 1st Visit Fee to include examination and report of findings			
• 2nd visit adjustment and subsequent adjustment appointments			
• Required re-examination fee (approx. every 30 days, in the event of a new injury and/ or every 12th visit and is in addition to the adjustment fee)			
• Dry Needling and/ or cupping added to an adjustment			

I acknowledge the Fees for Services have been reviewed and that I am ultimately responsibility for the fees for service.
Initial here _____

MEDICARE: Dr. Basler is a participating provider of Medicare. An examination to establish and continue care is required by your provider and Medicare however, Medicare will only reimburse medically necessary treatment and does not cover exams, re-exams, services other than spinal adjustments, x-rays, supportive care or maintenance care of a chronic condition. For this reason, it is important to follow the recommended frequency of care stated by the doctor. At the time of transition to supportive or maintenance care, Dr. Basler will review and ask you to sign an Advanced Beneficiary Notice (ABN); this is a written notice that the care from that date forward, in the doctor's opinion, will not be covered by Medicare and therefore, required to be paid out-of-pocket.

Thank you for the opportunity to serve you with specific Chiropractic Care.

Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient Name: _____ **Patient Number:** _____