Patient Information

Fort Wayne Chiropractic

Patient Last Name _____ **First Name** _____ **Middle Initial** _____

Name you prefer to go by: _____ **Date of Birth** _____ / _____ / _____ **SS#** _____

Gender: ☐ M ☐ F **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Home Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

Primary Number: ☐ Home ☐ Work ☐ Cell **Secondary Number:** ☐ Home ☐ Work ☐ Cell

Please check which source you would prefer for your appointment reminders. (Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone/computer it is only as safe as you and your phone/email company's security.)

☐ **Text appointment reminders**

☐ **Email appointment reminders** **email address:** _____

Your Employer _____ **Occupation** _____

Emergency Contact _____ **Phone Number** _____ **Relation** _____

Whom may we thank for your referral? _____

CONDITION **Workers Compensation Related?** ☐ Yes ☐ No **Auto Accident Related?** ☐ Yes ☐ No

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. It is important that you are familiar with these side effects before you consent to treatment.

The side effects associated with chiropractic treatment vary according to each patient's condition as well as the type of treatment. Possible side effects include: Common- Temporary worsening of symptoms. Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days. Sometimes- Sprain or strain. Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care. Rare- Rib fracture. While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of some weeks without further treatment or surgical intervention. Very rare- Aggravation of a herniated disc. Serious complications are rare in chiropractic. Therefore it is often not possible to determine if a worsening of symptoms is due to a treatment or the natural cause of the disc issue. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed. Extremely rare- Stroke: There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke.

The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I understand that if I am accepted as a patient by a physician at Fort Wayne Chiropractic I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be further explained to me upon request.

***Signature** _____ **Date** _____

My Privacy

I acknowledge that a copy of the Notice of Privacy Practices is available for me to review and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Fort Wayne Chiropractic to ensure the privacy of my personal health information.

***Signature** _____ **Date** _____

Financial Policy

Fort Wayne Chiropractic

Insurance: All patients are responsible for finding out their chiropractic coverage. We will be happy to submit your claims and assist you in getting your claims paid promptly. If you fail to provide our office with your correct insurance information, you will be held responsible for the balance on your account. All co-payments are due at the time services are rendered. If our office is not participating with your insurance company, you will be responsible for the complete balance your insurance requires. If you have not met your deductible, you are responsible for the full balance that insurance deems patient responsibility. It is your responsibility to ensure that the insurance referral is in place if your insurance carrier requires it. You authorize direct payment of your insurance benefits to Fort Wayne Chiropractic for chiropractic services rendered.

Self-Pay Patients: Our office offers a 15% time-of-service discount if services are paid for on the date of service or within 3 days of the date of service for patients with no insurance or for non-covered insurance services. Should you choose to submit an insurance claim for these services on your own, our office will not appeal any claims that are denied. Should the patient or the patient's insurance company request copies of treatment notes, the patient will be required to pay for these copies.

Returned Check: In addition to the face value of the check, you will be billed a return check fee of $25.00.

Billing: By being seen at Fort Wayne Chiropractic you accept responsibility for payment of all charges incurred, which may include a 20% interest fee after 4 months of a delinquent account, as well as all collection agency costs and/or attorney fees should such actions become necessary.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS **(Insured patients only)**
I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party below who accepts assignment.

All patients: by signing below you agree to everything in the above financial policy.

***Patient Name (print)** _____

***Patient Signature** _____ **Date** _____

For insured patients:
Is your insurance: ☐ Medicare ☐ Medicaid ☐ Through an employer ☐ Marketplace ☐Other _____

INSURANCE SUBSCRIBER INFORMATION: *If the subscriber is the patient, this section does not need to be filled out*

Full Name _____ Date of Birth _____ /_____ /_____

Relationship to Patient _____ Home Address _____

City _____ State _____ Zip _____ Home Phone # _____

Failed Appointment Policy

We require that you call at least 24 hours in advance to cancel your scheduled appointment. A cancellation that is not made 24 hours in advance is considered a failed appointment. To cancel your appointment, please call Fort Wayne Chiropractic at (260) 492-8300. Do not cancel your appointment by replying to the text message or email reminders.

Appointments are scheduled every 15 minutes. If you are 15+ minutes late arriving to your scheduled appointment, this is also considered a failed appointment.

If you have 3 failed appointments during the calendar year you will incur a $25 charge. You are responsible for any failed appointment charges that you may incur. Your insurance company does not allow this charge; therefore we will not bill your insurance.

By signing below, you understand and agree to adhere to the Fort Wayne Chiropractic Failed Appointment Policy.

***Signature** _____ **Date** _____

We encourage you to take a detailed Office Information and Policies Pamphlet that is available at the check-in counter. This pamphlet should answer any questions you have about Fort Wayne Chiropractic and our policies.

PERMISSION TO SHARE LIMITED HEALTH INFORMATION

Fort Wayne Chiropractic

Patient Name (print) _____ **Date Of Birth** _____

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Name of individual (parents and spouses must be added if they are to have any access)	**Relationship with patient**	**Specify Information Allowed**
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____

Fort Wayne Chiropractic has my permission to: **(Please check all that apply)**

☐ Leave detailed message **at home** with: NAME: _____ Relationship:_____

☐ Leave detailed message on my **home answering machine** Home phone number: _____

☐ Leave detailed message on my **cell phone voicemail** Cell phone number: _____

☐ Leave detailed message on my **work phone voicemail** Work phone number: _____

*In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to confirm the patient's date of birth with the staff.

_____ _____

*Signature of patient or legal guardian Date

Pain Assessment

Patient Name _____ **Date** _____

Please only check one body area per complaint box.
The doctor will only work on areas that you mark on this pain assessment.

Were you referred to us by another medical provider for your complaints? If yes, who? _____

Complaint #1 (main complaint)

Body Area: ☐ Head ☐ Jaw ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Buttocks ☐ Hip ☐ Ribs
☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Hand ☐ Wrist ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Foot

What side of body: ☐ Right ☐ Left ☐ Right and Left ☐ Middle **Front or back of body:** ☐ Front ☐ Back

Symptom frequency throughout the day : ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Symptoms: ☐Ache ☐Burning ☐Dull ☐Headache ☐Numbness ☐Pain ☐Sharp ☐Shooting ☐Spasms ☐Stiff ☐Tender ☐Throbbing ☐Tingling

When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

_____

Have you had this issue in the past? ☐ Yes ☐ No

Since your symptoms began, have they... ☐ Mildly improved ☐ Improved ☐ Mildly worsened ☐ Worsened ☐ Stayed the same

Current symptom severity ☐ **0** (none) ☐ **1** (very mild) ☐ **2** (discomfort) ☐ **3** (tolerable) ☐ **4** (distressing) ☐ **5** (very distressing)
☐ **6** (intense) ☐ **7** (very intense) ☐ **8** (horrible) ☐ **9** (unbearable) ☐ **10** (near unconsciousness)

When do your symptoms occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ After work ☐ Other _____

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves your symptoms? (ex: lying down) _____ **What makes them worse?** _____

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ☐ Yes ☐ No **If yes, to where** _____

What medical care have you received for this latest occurrence of symptoms? _____

Complaint #2

Body Area: ☐ Head ☐ Jaw ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Buttocks ☐ Hip ☐ Ribs
☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Hand ☐ Wrist ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Foot

What side of body: ☐ Right ☐ Left ☐ Right and Left ☐ Middle **Front or back of body:** ☐ Front ☐ Back

Symptom frequency throughout the day : ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Symptoms: ☐Ache ☐Burning ☐Dull ☐Headache ☐Numbness ☐Pain ☐Sharp ☐Shooting ☐Spasms ☐Stiff ☐Tender ☐Throbbing ☐Tingling

When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

_____

Have you had this issue in the past? ☐ Yes ☐ No

Since your symptoms began, have they... ☐ Mildly improved ☐ Improved ☐ Mildly worsened ☐ Worsened ☐ Stayed the same

Current symptom severity ☐ **0** (none) ☐ **1** (very mild) ☐ **2** (discomfort) ☐ **3** (tolerable) ☐ **4** (distressing) ☐ **5** (very distressing)
☐ **6** (intense) ☐ **7** (very intense) ☐ **8** (horrible) ☐ **9** (unbearable) ☐ **10** (near unconsciousness)

When do your symptoms occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ After work ☐ Other _____

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves your symptoms? (ex: lying down) _____ **What makes them worse?** _____

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ☐ Yes ☐ No **If yes, to where** _____

What medical care have you received for this latest occurrence of symptoms? _____

Pain Assessment (page 2)

Patient Name _____ **Date** _____

Please only check one body area per complaint box.
The doctor will only work on areas that you mark on this pain assessment.

Complaint #3

Body Area: ☐ Head ☐ Jaw ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Buttocks ☐ Hip ☐ Ribs
☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Hand ☐ Wrist ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Foot

What side of body: ☐ Right ☐ Left ☐ Right and Left ☐ Middle **Front or back of body:** ☐ Front ☐ Back

Symptom frequency throughout the day : ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Symptoms: ☐Ache ☐Burning ☐Dull ☐Headache ☐Numbness ☐Pain ☐Sharp ☐Shooting ☐Spasms ☐Stiff ☐Tender ☐Throbbing ☐Tingling

When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

_____

Have you had this issue in the past? ☐ Yes ☐ No

Since your symptoms began, have they... ☐ Mildly improved ☐ Improved ☐ Mildly worsened ☐ Worsened ☐ Stayed the same

Current symptom severity ☐ **0** (none) ☐ **1** (very mild) ☐ **2** (discomfort) ☐ **3** (tolerable) ☐ **4** (distressing) ☐ **5** (very distressing)
☐ **6** (intense) ☐ **7** (very intense) ☐ **8** (horrible) ☐ **9** (unbearable) ☐ **10** (near unconsciousness)

When do your symptoms occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ After work ☐ Other _____

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves your symptoms? (ex: lying down) _____ **What makes them worse?** _____

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ☐ Yes ☐ No **If yes, to where** _____

What medical care have you received for this latest occurrence of symptoms? _____

Complaint #4

Body Area: ☐ Head ☐ Jaw ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Buttocks ☐ Hip ☐ Ribs
☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Hand ☐ Wrist ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Foot

What side of body: ☐ Right ☐ Left ☐ Right and Left ☐ Middle **Front or back of body:** ☐ Front ☐ Back

Symptom frequency throughout the day : ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Symptoms: ☐Ache ☐Burning ☐Dull ☐Headache ☐Numbness ☐Pain ☐Sharp ☐Shooting ☐Spasms ☐Stiff ☐Tender ☐Throbbing ☐Tingling

When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

_____

Have you had this issue in the past? ☐ Yes ☐ No

Since your symptoms began, have they... ☐ Mildly improved ☐ Improved ☐ Mildly worsened ☐ Worsened ☐ Stayed the same

Current symptom severity ☐ **0** (none) ☐ **1** (very mild) ☐ **2** (discomfort) ☐ **3** (tolerable) ☐ **4** (distressing) ☐ **5** (very distressing)
☐ **6** (intense) ☐ **7** (very intense) ☐ **8** (horrible) ☐ **9** (unbearable) ☐ **10** (near unconsciousness)

When do your symptoms occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ After work ☐ Other _____

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves your symptoms? (ex: lying down) _____ **What makes them worse?** _____

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ☐ Yes ☐ No **If yes, to where** _____

What medical care have you received for this latest occurrence of symptoms? _____

Patient Health History

Fort Wayne Chiropractic

Patient Name _____

Please mark the below issues you currently have, or have had in the past

Musculoskeletal

- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Muscle spasms
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Upper back pain
- ☐ Neck pain
- ☐ Arm/Leg pain
- ☐ Broken bones
- ☐ Fractured bones
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Implants/plates

Neurological

- ☐ Seizures
- ☐ Vertigo
- ☐ Dizziness
- ☐ Incoordination
- ☐ Weak grip
- ☐ Paralysis
- ☐ Difficult speech
- ☐ Tingling
- ☐ Loss of memory
- ☐ Numbness
- ☐ Tremors
- ☐ Fainting
- ☐ Parkinsons
- ☐ Concussion
- ☐ Alzheimers
- ☐ Multiple sclerosis
- ☐ Stroke

Head/ENT

- ☐ Hearing Defect/Loss
- ☐ Headaches or migraines
- ☐ Ringing in ear(s)
- ☐ TMJ problems

Cardiovascular

- ☐ Chest pain/discomfort
- ☐ Shortness of breath
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

☐ **I currently have none of the above issues nor have I had them in the past**

Have you had any imaging scans in the past that are relevant to today's treatment?
☐ **NONE**

Date _____ Body area _____ Results _____ ☐X-ray ☐MRI ☐CT

Date _____ Body area _____ Results _____ ☐X-ray ☐MRI ☐CT

Date _____ Body area _____ Results _____ ☐X-ray ☐MRI ☐CT

Have you had any hospitalizations or surgeries in the past that are relevant to today's treatment?
☐ **NONE**

Date _____ Reason/Type of surgery _____ ☐ Surgery ☐ Hospitalization

Date _____ Reason/Type of surgery _____ ☐ Surgery ☐ Hospitalization

Date _____ Reason/Type of surgery _____ ☐ Surgery ☐ Hospitalization

Have you had any injuries in the past, other than those listed above, that are relevant to today's treatment? ☐ **NONE** _____

_____

Relevant Family History (ex: father-arthritis): ☐ **NONE** _____

Lifestyle Habits: work _____ hours per week -- ☐light labor ☐moderate labor ☐heavy labor ☐repetitive ☐ computer ☐mostly sitting ☐mostly standing ☐mostly walking ☐difficult ☐stressful

Exercise Habits: ☐ Weekly ☐ Daily ☐ None

Patient Signature _____ **Date** _____