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Initial Intake Questionnaire

*Instructions: Please take time to provide full and complete responses to the questions below. If you need additional room to respond to a question, please use the backside of this questionnaire.

Patient Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (Check one)

First Name: _____Middle Initial:_____Last Name: _____
Address:_____
City:_____ State:_____ Zip:_____
Mobile #: (____) _____-_____ Sex: Male ☐ Female ☐ Other ☐
Email: _____Marital Status: ☐ Single ☐ Married ☐ Other
Date of Birth: ____/_____/_____ Social Security #:_____

Employer Data:
Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Other
Employer Name: _____ Telephone #: (____) _____-_____

Emergency Contact:
Name: _____ Telephone #: (____) _____-_____

Policy Holder on Insurance:
☐ Patient/Listed above ☐ Other: _____ (Relation to Policy Holder) Ex: Spouse, Child
If you selected other, please put the name and address below.
First Name: _____ Last Name: _____ DOB: _____
Address:_____ City:_____ State:_____ Zip:_____

To whom do we send bills to? ☐Patient/ Address listed above ☐ other:
If you selected other, please put the name and address below.
First Name: _____ Last Name: _____
Address:_____
City:_____ State:_____ Zip:_____

How did you hear about our clinic?

- ☐ Family Member
- ☐ Friend
- ☐ Physician
- ☐ Employer
- ☐ Yellow Pages
- ☐ Internet
- ☐ Sign on Building
- ☐ Radio
- ☐ Health Class
- ☐ Website
- ☐ Brochure
- ☐ Other

Who can we thank for your referral?

_____

If you selected "other" please describe

_____

Medical Conditions

- ☐ Arthritis
- ☐ Heart Disease
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Hypertension
- ☐ Psychiatric Illness
- ☐ Cancer
- ☐ Diabetes
- ☐ Other:_____

Surgeries:

- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Cardiovascular
- ☐ Radical prostatectomy
- ☐ Joint Replacement
- ☐ Laminectomies
- ☐ Cervical disc
- ☐ Transurethral prostate
- ☐ Other:_____

Allergies:

- ☐ Eggs
- ☐ Fish & Shellfish
- ☐ Milk or Lactose
- ☐ Peanut
- ☐ Soy
- ☐ Sulfites
- ☐ Wheat/ Gluten
- ☐ Other:_____

Social History:

Caffeine Use: ☐ Occasionally ☐ Often Tobacco Use: ☐ Occasionally ☐ Often

Alcohol Use: ☐ Occasionally ☐ Often Exercise: ☐ Occasionally ☐ Often

Stress: ☐ Occasionally ☐ Often Smoke: ☐ 1 pack or less ☐ 1 pack+

Wear seat belt: ☐ Always ☐ Never ☐ Usually

Family History: (P) = Parent (S) = Sibling

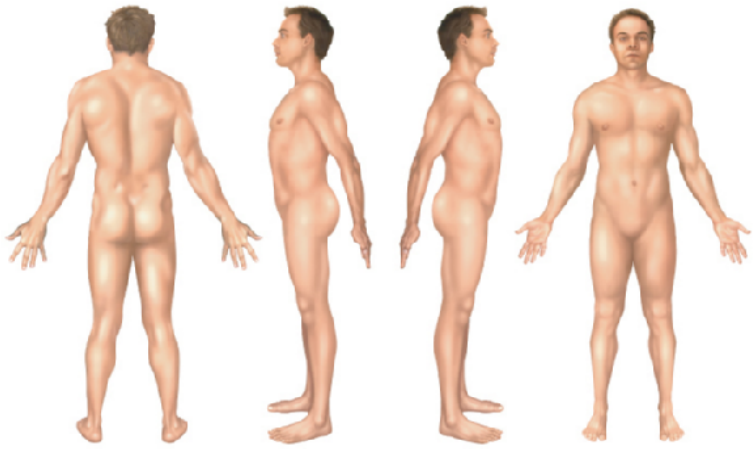
- ☐ Arthritis (P)
- ☐ Arthritis (S)
- ☐ Cancer(P)
- ☐ Cancer(S)
- ☐ Cholesterol (P)
- ☐ Cholesterol (S)
- ☐ Diabetes (P)
- ☐ Diabetes(S)
- ☐ Heart (P)
- ☐ Heart (S)
- ☐ H. Blood Pressure (P)
- ☐ H. Blood Pressure (S)
- ☐ Psychiatric (P)
- ☐ Psychiatric (S)
- ☐ Stoke (P)
- ☐ Stroke (S)
- ☐ Thyroid (P)
- ☐ Thyroid (S)

Occupational Activities:

- ☐ Administration
- ☐ Business Owner
- ☐ Clerical/Secretarial
- ☐ Computer User
- ☐ Construction
- ☐ Daycare/childcare
- ☐ Executive/legal
- ☐ Food Service
- ☐ Health care
- ☐ Heavy eqpt. operator
- ☐ Heavy Labor
- ☐ Home services
- ☐ Household
- ☐ Light Labor
- ☐ Manufacturing
- ☐ Medium Labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X= Burning / = Stabbing 0 = Pins & Needles + Dull Ache



Describe your symptoms:

_____

_____

When did your symptoms start? Month_____ Day_____ Year_____

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0- 25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0=none to 10= Unbearable)

☐ 0 None ☐ 1 ☐ 2 ☐ 3
☐ 4 ☐ 5 ☐ 6 ☐ 7
☐ 8 ☐ 9 ☐ 10 Unbearable

During the past 4 weeks, how much pain has interfered with your normal work (including both work outside the home and housework):

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit
☐ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time
☐ None of the time

In general, would you say your overall health right now is…?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms?

☐ No One ☐ Other Chiro. ☐ Medical Doctor ☐ Physical Therapist ☐ Other

When did you receive this treatment?

☐ In the last month ☐ 2-3 months ago ☐ 3-6 months ago ☐ 6-12 months ago
☐ 1-2 years ago ☐ 2-5 years ago ☐ 5-10 years ago

What tests have you had for your symptoms

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other

When were these tests done?

☐ In the last month ☐ 2-3 months ago ☐ 3-6 months ago ☐ 6-12 months ago
☐ 1-2 years ago ☐ 2-5 years ago ☐ 5-10 years ago

Have you had similar symptoms in the past?

☐ Yes ☐ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

☐ This office ☐ Other Chiro. ☐ Medical Doctor ☐ Physical Therapist ☐ Other

What is your occupation?

☐ Professional/Executive ☐ FT Student ☐ Tradesperson ☐ Laborer
☐ White Collar/ Secretarial ☐ Homemaker ☐ Retired ☐ Other

If you are not retired, a homemaker, or a student, what is your work status?

☐ Full- Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed
☐ Off Work ☐ Other

Review of Systems:

Have you had trouble with any of the following?

Cardiovascular: No☐

	Present	Past	No
Poor Circulation	☐	☐	☐
High Blood Pressure	☐	☐	☐
Aortic Aneurism	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Attack	☐	☐	☐
Chest Pain	☐	☐	☐
High Cholesterol	☐	☐	☐
Pace Maker	☐	☐	☐
Jaw Pain	☐	☐	☐
Irregular Heart Beat	☐	☐	☐
Swelling of the Legs	☐	☐	☐

Hematologic/ lymphatic: No☐

	Present	Past	No
Hepatitis	☐	☐	☐
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy Bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fevers/ Chills/ Sweats	☐	☐	☐

Neurologic: No☐

	Present	Past	No
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Head Injury	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Numbness	☐	☐	☐
Severe Headaches	☐	☐	☐
Pinches Nerves	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Carpal Tunnel	☐	☐	☐
Spinning/ Balance	☐	☐	☐

Constitutional: No☐

	Present	Past	No
Weight loss/ gain	☐	☐	☐
Energy Level Problem	☐	☐	☐
Difficulty Sleeping	☐	☐	☐

Respiratory: No☐

	Present	Past	No
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Ears/Nose/Throat: No☐

	Present	Past	No
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Eyes: No☐

	Present	Past	No
Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐
Blurred Vision	☐	☐	☐

Integumentary: No☐

	Present	Past	No
Skin Ulcers	☐	☐	☐
Skin Disease	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐

Psychiatric: No☐

	Present	Past	No
Depression	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Unusual Stress	☐	☐	☐

Allergic/Immunologic: No☐

	Present	Past	No
Hives	☐	☐	☐
Immune Disorder	☐	☐	☐
HIV/AIDS	☐	☐	☐
Alergy Shorts	☐	☐	☐
Cortisone Use	☐	☐	☐

Gastrointestinal: No☐

	Present	Past	No
Gallbladder Problems	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Liver Problems	☐	☐	☐
Ulcers	☐	☐	☐
Diarrhea	☐	☐	☐
Nausea/ Vomiting	☐	☐	☐
Bloody Stools	☐	☐	☐
Poor Appetite	☐	☐	☐

Musculoskeletal: No☐

	Present	Past	No
Gout	☐	☐	☐
Arthritis	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken Bones	☐	☐	☐
Joint Replaced	☐	☐	☐

Endocrine: No☐

	Present	Past	No
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐

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Financial and Office Policy

Insurance:

- **Patient is responsible for understanding their insurance benefits.**
- Active Wellness Chiropractic and Rehabilitation (AWCR) is not responsible for providing benefit information and that any information given to Patient is not a guarantee of benefits.
- AWCR will submit all claims to Primary and Secondary Carriers (if applicable).
- Patient authorizes AWCR to submit insurance claims on their behalf, and to accept payment of medical benefits for services rendered.
- Patient authorizes AWCR to initiate a complaint to their insurance company, and/or Insurance Commissioner on their behalf.
- Patient authorizes the release of medical information to their Insurance Company, Adjuster, or Attorney involved in the processing of their claims.
- In the event that Patient's Insurance Company remits payment to AWCR with a check made out in Patient's name, Patient authorizes AWCR to deposit that payment and credit Patient's account accordingly.

Financial Agreement and Patient Balances:

- **Patient is ultimately responsible for their account balance regardless of insurance coverage. ____*Initial***
- AWCR may ask for a copy of a major credit card to keep on file in a secure server. Patient authorizes AWCR to charge their credit card on file with any unpaid balances that are greater than 30 days old that exist after the Insurance Company sends payment for that claim.
- Patient will provide new contact and credit card information to AWCR front desk whenever the information changes.
- AWCR will send monthly statements to Patients with current balances.
- Patient is responsible for payment of medical services rendered.
- Patient is responsible for any co-payment, co-insurance, deductible and/or non-covered services.
- There will be a $35 services charge for returned or bounced checks.
- If your account is turned over to an outside collection agency, your balance will be increased by 33% to cover the cost of the collection agency's fee.

Missed or Late Appointments:

- Appointment times are reserved for you and we make every effort to keep to our scheduled appointment times. If you are more than 5 minutes late for an appointment, we may ask for you to reschedule in order to get the full attention from our treatment staff.
- **Patient understands that there will be a $65 charge for a missed or cancelled appointment unless 24 hour notice had been given to AWCR. This fee is not covered by insurance and is due before your next visit.**

I understand and accept the terms of the Financial and Office Policy listed above.

Print Patient Name: _____ Print Parent or Guardian Name: _____
Electronic Signature of Patient or Parent/Guardian: _____ Date: _____

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Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible).

I understand and am informed that, as in the practical medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name_____ Electronic Signature of Patient_____

Date Signed _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR

Electronic Signature of Representative_____Date _____

Relationship or Authority of Patient's
Representative_____

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient and "Chiropractor" refers to Active Wellness Chiropractic & Rehabilitation.

I consent to the use of disclosure of my protected health information by chiropractor for the purposes of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand the analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have to right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 8711 Windsor Pkwy, Suite 7, Johnston, IA 50131. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Electronic Signature of Patient Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

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Informed Consent for Text Message or Email

Client Information:

Name: _____ Email Address: _____

Phone Number: _____

Note: In order for us to correspond via txt or email, it is necessary to sign the Email Consent Form

A. **Risk of using text messages**. Active Wellness occasionally offer clients the opportunity to communicate via text messages. Transmitting client information by text messaging has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:

- Text messages can be circulated, forwarded or stored in electronic files
- Text messages can be immediately broadcast worldwide and received by many intended and unintended recipients.
- Senders can easily misaddress a text message.
- Text messaging is easier to falsify than handwritten or signed documents.
- Backup copies may exist even after sender and/or recipient has deleted their copies
- Text messages can be intercepted, altered, forwarded or used without detection or authorization
- Text messages can be lost in transmission

B. **Conditions for the use of text messaging.** We will use reasonable means to protect the security and confidentiality of text messaging information sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of text messaging communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. **Therefore, clients will need to specifically grant permission for the use of text messaging.** Consent to the use of text messages includes agreement with the following conditions:

C. **Instruction for communicating via text messaging**

- Inform us in writing of changes in text messaging address/phone number
- Put the clients name and purpose of text message in the subject line
- Send a reply message or delivery receipt to us to acknowledge clients' receipt of any text messaging.
- Withdraw consent to utilize text messaging only by written communication.

Patient acknowledgement and agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. In addition

☐ I would like to receive Text Messages and Emails

☐ Please exclude me from text message appt. reminders and email information regarding my appt.

Electronic Patient Signature: _____Date: _____

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Over 18 HIPAA Release and Consent Form

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Active Wellness will not speak with anyone without my written consent in accordance with this document.

☐ **I DO NOT** grant any access to my medical information, records, or appointment information.

☐ **I WISH TO** grant access to my healthcare providers and/ or medical information to the following.

_____/_____(Print Name; Indicate his/her relationship to you)

_____/_____(Print Name; Indicate his/her relationship to you)

I give the above-named individual(s) permission to contact and speak with any physician or member of the staff regarding my care. I understand that I can withdraw consent at any time by providing Active Wellness a written notice indicating the change.

_____ _____

Patient Printed Name **DATE**

_____

Electronic Patient Signature