577 Braund Street, Onalaska, WI 54650
(608) 406-2488

CHIROPRACTIC INTAKE

PATIENT INFORMATION Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Age _____

Address _____ Sex: Male _____ Female _____

City/State/Zip _____

Cell Phone # _____ Home/Other Phone # _____

Email Address _____

Single _____ Married _____ Divorced _____ Widowed _____ # Of Children _____

Occupation _____ Height _____ Weight _____

Emergency Contact _____ Phone _____

How did you hear about our office? (Please circle all that apply) GOOGLE/INTERNET FACEBOOK

HEALTH EVENT DOCTOR/MEDICAL PROVIDER FAMILY MEMBER/FRIEND

OTHER: _____ Please tell us whom we can thank for referring you to us _____

Information about Possible Risk of Chiropractic Treatment

_____ I understand that I have the right, as a patient, to be informed about my condition and the recommended integrative and complementary procedure to be used so that I may make an informed decision whether to undergo the procedure after knowing the risks and hazard involved. Chiropractors, medical doctors, and physical therapists using manual therapy treatment for patients are required to explain that there have been rare cases of injury. Appropriate tests will be performed to help identify if you may be susceptible to injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak to your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, fractures, and disk, cardiovascular, or physiotherapy complications. These are extremely rare occurrences.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Authorization to treat a minor (under the age of 18)

_____ I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all other doctors and interns in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named below. If my authority to select and authorize this care should be revoked or modified in anyway, I will immediately notify River City Chiropractic.

_____ _____
Print Name of Patient Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

RIVER CITY
CHIROPRACTIC

577 Braund Street, Onalaska WI 54650
(608) 406-2488

OFFICE FINANCIAL POLICY

DIRECT PAY: _____ This office accepts all major credit cards, cash, and personal checks.

INSURANCE: MEDICAL _____ AUTO _____ PI _____ W/C _____

It is the patient's responsibility to pay the insurance co-payment on the date of service. Any co-insurance and/or non-covered services are expected to be paid at the time of service, or when the patient/responsible party is billed. The office may make payment plan arrangements on an individual basis. Any such plan or arrangement must be made before the account is past due.

River City Chiropractic accepts assignment as a courtesy to the patient. Should the insurance company not pay any of the anticipated charges for any reason, the patient/responsible party is ultimately responsible for the entire bill. We are not the mediator between you and the insurance company, and we will not enter into any dispute with them, as your contract is between you and your insurance company.

All insurance payments, regardless of which company issues check first, are applied to the patient's account if any balance is due. Refunds are only made after a patient's balance is completely cleared with this office.

If the patient changes contact information or insurance companies, the patient agrees to provide the doctor's office with current information as soon as it is available.

Please read thoroughly, initial at each section and sign at the bottom. Thank you.

Authorization to release information

_____ I have been given access to the Privacy Notice and understand my rights contained in the notice. By way of signature, I authorize this healthcare facility to release all information related to the care I receive for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Assignment of Benefits

_____ I assign all benefits payable to me for my care to River City Chiropractic S.C. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this healthcare facility.

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____ _____
Print Name of Patient Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

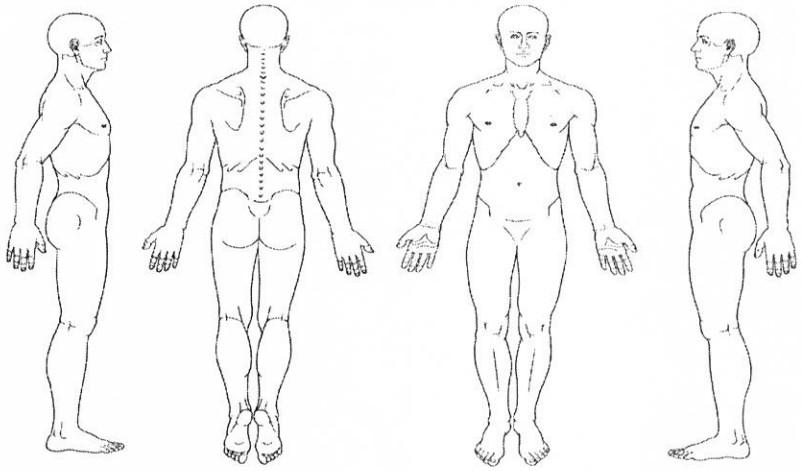
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None									Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

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

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

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

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____