Heiden Chiropractic
11378 Chase St
Trempealeau, WI 54661
p 608.534.6090
trempealeaufamilychiro.com

Patient Profile

Full Name: ____ *Jr / Sr*

First *M.I.* *Last*

Birth Date: ______________ **Gender**: Male Female

Marital Status: Single Married **Employment Status**: FT PT Student Retired

Race: White Asian African American Pacific Islander Declined Other: ______________

Ethnicity: Hispancic or Latino Not Hispanic or Latino Declined Other: ______________

Primary Language: English Spanish Other__________

Address:____

Street Address Apartment/Unit #

____

City State ZIP Code

Primary Phone:__________________________ **Cell/Alternate Phone:** _______________________

Email Address:____

Emergency Contact:_____________________________________

Emergency Contact Phone:_________________________

Have you received Chiropractic care elsewhere this year? Yes No

How did you choose our office? (circle one)

Phone book, radio ad, newspaper,

internet, referral, other ___________

If referred who may we thank for your referral? _____________________________________

Patient Name ________________________________ Date________________

Regarding Personal Health Information:

Is it okay for the office staff to send you a text reminder for your appointment and/or email other pertinent information?

Yes No

Is it okay for the office to leave a voice mail about upcoming appointments or other pertinent information?

Yes No

Health Insurance?

Yes No

Insured Party: You Other (parent, spouse, etc.)

Insured Information:

Relationship to You:___________________________

Full Name:____

First M.I. Last

Same as your address? Yes No

Address:____

Street Address Apartment/Unit #

____

City State ZIP Code

*Phone number*___________________________

Date of Birth ____________________________

Employer of Insured Party: ____

For Work Comp Injury Only

Employer

Employer Name:____

Employer Phone:_______________________ Ext. ______ Fax:_____________________

Is this injury related to an auto accident? YES NO

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Patient Name: ________________________

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:
http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _________

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, spinal manipulative therapy, range of motion testing, muscle strength testing, EMS, Ultrasound, and X-rays.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. This is the same rate of stroke determined in studies for people getting their hair washed at a salon, looking behind you while driving, and as determined in one study it the same rate of occurrence when patients went to their MD without being adjusted. Here at Trempealeau and Independence Family Chiropractic we offer light force neck adjustments using an instrument when you have increased risk factors to stroke or other conditions. The other complications are also generally described as rare.

Initial _________

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.
The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.
Initial _________

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.
The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.
I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial _________

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

This office reserves the right to charge a $20 fee for missed appointments or appointments canceled without notification of at least 1 hour. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance.

Signature of Patient or Guardian (if a minor) ____________________________ Date _____________

Patient: ______________________________________

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Name: ____

Date: ____________ Email address: ___________________________

Health History Form

What is your approximate height? ________ What is your approximate weight? ________ lbs

Have you ever smoked cigars or cigarettes? ☐ Yes ☐ No

Do you still smoke? ☐ Yes ☐ No

How much do you smoke? ☐ Less than one pack per week ☐ 1-2 packs per week

☐ 1 pack every two days ☐ 1 pack per day ☐ More than one pack per day

Do you exercise regularly? ☐ Yes ☐ No

Are you pregnant or trying to get pregnant? ________

Check if you have any implants, screws, plates or other foreign objects in your body. ☐ Yes No

☐ Bullet Wound(s) ☐ Infusion Catheter ☐ Ear Implant ☐ Pacemakers ☐ Eye Implant

☐ Brain Plate(s) ☐ Heart Valve(s) ☐ Shrapnel ☐ Other ____________________

Musculoskeletal Surgeries (Please list any surgeries) i.e. hip, knee ect.

Please describe: ________________________________ Year(s) of surgery: ________________

Please describe: ________________________________ Year(s) of surgery: ________________

Please describe: ________________________________ Year(s) of surgery: ________________

Organ System Surgeries (Please list any surgeries) i.e. appendix, gallbladder, hysterectomy ect.

Please describe: ________________________________ Year(s) of surgery: ________________

Check if a physician has ever diagnosed you with cancer. ☐ Yes ☐ No

Please describe: ________________________________ Year(s) of surgery: ________________

Please describe: ________________________________ Year(s) of surgery: ________________

Allergies: ______________________ ______________________ ______________________ ______________________

Medications: ______________________ ______________________ ______________________ ______________________
(If you have a list with you, we will copy it instead)

Patient Name ______________________________ Date________________

Check **if you currently have or have had in the past any of the following conditions:**

	Past	Present		Past	Present
Headaches	☐	☐	Shoulder pain	☐	☐
Eye problems	☐	☐	Ear problems	☐	☐
Asthma	☐	☐	Sinus problems	☐	☐
Thyroid problem	☐	☐	Digestive issues	☐	☐
Acid reflux	☐	☐	Gall bladder	☐	☐
Anxiety	☐	☐	Depression	☐	☐
Neck pain	☐	☐	Mid back pain	☐	☐
Low back pain	☐	☐	High blood pressure	☐	☐
Wrist pain	☐	☐	Elbow pain	☐	☐
Foot/Ankle pain	☐	☐	Arthritis	☐	☐
Dizziness	☐	☐	Rheumatoid arthritis	☐	☐
Heart attack	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Other________________________________		
Diabetes	☐	☐	Do you hear cracking/grinding in your neck? Yes No		

Chief Complaint Form

Describe the reason for your visit: ____

____

When did your symptoms begin? (select one)
☐ Today ☐ This week ☐Within last 3 months ☐ 3 months to 6 months
☐ 6 months to one year ☐ ________________________

For Women Only
Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)
☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe changes in your discomfort during the day? (select one or more)
☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night
☐ It changes with the weather ☐ It does not change

What helps relieve your discomfort? (select one or more)
☐Ice ☐ Heat ☐Medication ☐Other (please describe) __________________________

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Coughing ☐ Daily Routine ☐ Driving ☐ Getting Up ☐ Lifting ☐ Sitting ☐ Sleeping

☐ Standing ☐ Looking up/down ☐ Walking ☐ Working ☐ Exercise ☐ Twisting ☐ Movement ☐ Household Chores

Do you consume caffeine? If so how much? ___________________
Do you consume alcohol? If so how much? ____________________
How much water do you drink? ________________________________