Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: Date: / /

SS#: - - DOB: / / Sex: M F

Marital Status: # of Children: Occupation:

Street Address: Height: ft. in.

City: State: Zip: Weight: lbs.

Email: Cell Phone: - - Other Phone: - -

Emergency Contact: Emergency Relation: Emergency Phone: - -

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? Yes No

- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.

X=Current condition; O=Past condition

Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. ______

2. ______

3. ______

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ○ Resolve existing condition(s) ○ Overall wellness ○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what is their name?

What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutritional ○ Subluxation-based ○ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No
- If yes, please explain:

Notable childhood injuries? ○ Yes ○ No If yes, please explain:

Youth or college sports? ○ Yes ○ No If yes, list major injuries:

Any auto accidents? ○ Yes ○ No If yes, please explain:

Exercise Frequency? ○ None ○ 1-2x per week ○ 3-5x per week ○ Daily
What types of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*
Alcohol	①	②	③	④	⑤
Water	①	②	③	④	⑤
Sugar	①	②	③	④	⑤
Dairy	①	②	③	④	⑤
Gluten	①	②	③	④	⑤

	None		*Moderate*		*High*
Processed Foods	①	②	③	④	⑤
Artificial Sweeteners	①	②	③	④	⑤
Sugary Drinks	①	②	③	④	⑤
Cigarettes	①	②	③	④	⑤
Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*
Home	①	②	③	④	⑤
Work	①	②	③	④	⑤
Life	①	②	③	④	⑤

	None		*Moderate*		*High*
Money	①	②	③	④	⑤
Health	①	②	③	④	⑤
Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

Patient Name: ______________________________ Date: __/__/____

Dr. Rondle Bennett | North Island Chiropractic and Wellness Center
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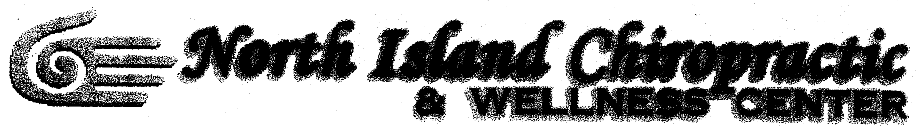

Informed Consent for the Chiropractic Patient:

To the Patient: Please read document and sign. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or 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 part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.

Authorization for the release of patient information: I hereby authorize Messer Chiropractic to provide other health care providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care.

Do not sign until you have read and understand the above. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to understand the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

Date:______________________________

Patient's Signature:____

Signature of parent/guardian (if minor)_______________________________

Dr. Rondle Bennett, DC

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Financial Policy

Our primary concern is for your health. Below are the options available to address your financial needs. Please read the following, initial the choice most appropriate for you and sign where indicated. Thank you.

To all our insured patients: as a courtesy to you, we will submit your billing to your insurance carrier for you. Insurance is an agreement between you and your insurance carrier. If your insurance company has a policy in which payments for services rendered are paid directly to you rather than to the clinic, payment is due in full at the time of service. Should your insurance company deny payment for any reason, the balance due is still your responsibility.

Accounts over ninety (90) days outstanding will be acted upon for collection. Collection costs are added to your account. A late fee of one percent (1%) accrued per month is charged on overdue accounts.

I understand and agree to the above financial policy and will abide by the terms of the PAYMENT OPTION I have initialed below.

Signature: ______________________________ Date: ________________

PAYMENT OPTIONS: Please initial your choice.

_____ 1. **Cash/Check/Credit Card:** PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE. No billing is available for this option.

_____ 2. **Health Insurance:** We recommend you call and verify your chiropractic benefits with your insurance company prior to your first visit. As a courtesy to you, we will also call to verify your coverage and discuss it with you.
CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

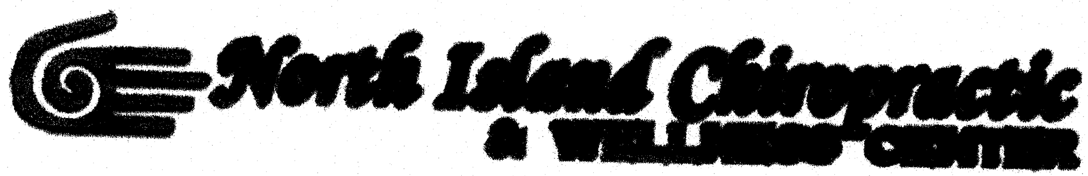
_____ 3. **On the Job Injuries (L&I):** Please notify your employer of your injury so they may file the necessary forms with your workers compensation carrier. In an accepted claim, industrial insurance pays 100%. If the claim is disallowed or transfer of physician is not approved, industrial insurance does not cover any of the services rendered and the bill is your responsibility.

_____ 4. **Motor Vehicle Accident:** We bill your insurance company on your Personal Injury Protection (PIP). Notify your insurance company or agent that you are under care at this office. A medical lien is placed on the claim to protect your medical payment benefits. Patients without PIP use payment options #1 or #2 until the time of settlement or until the balance is paid in full.

_____ 5. **Medicare:** Medicare will cover a portion of visits per year after your deductible has been met. We are happy to bill your co-insurance (secondary) for you. Medicare does not cover examinations, x-rays, supplies, or maintenance visits. Payment for services not covered by Medicare are due when rendered. Please see Medicare Advance Beneficiary Notice form.

Authorization to Release Information: I hereby authorize North Island Chiropractic & Wellness to release any information requested by the insurance company to process the claim.

Signature: ______________________________ Date: ________________



Cancellation and No Show Policy

Thank you for choosing North Island Chiropractic & Wellness Center for your chiropractic needs. We understand that unanticipated events occasionally do happen, and sometimes it is necessary to reschedule appointments.

If you Cancel on short notice, do not show up, or show up very late- that is an opportunity for another patient to receive the care they need.

Please read the following policies and sign your name below. If you have any questions, please let out staff know. We look forward to being a continued part of your wellness.

Late Arrivals

If you are running late to your appointment, please notify our office as soon as possible. We will do the best we can to fit you into the schedule. If needed, we can reschedule you for another day and time.

Cancellations

Advanced notice is required when cancelling any appointment. If you need to cancel your appointment, please contact us ASAP or at least within 24 hours of your schedule appointment. If you are unable to reach us directly, you may leave a message on our voicemail.

No Shows

If you do not call our office to cancel or if you miss your appointment, this will be considered a "no show". One no show will result in no penalty, however any "no shows" after your first will result in a **$20.00** fee. The $20 fee will be billed to you directly and will need to be paid in full before your next visit.

I have read and understand the cancellation and no-show policy for North Island Chiropractic & Wellness Center, and I agree to be bound by its terms.

Patient Name (Print)______________________________

Patient Signature__________________________________ Date______________________________

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