

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone (work) _____ (home) _____ Referred By _____
Age _____ Birth date _____ Social Security # _____ Number of children _____
Occupation _____ Employer _____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's health status _____
Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* Work Other
Please describe _____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? No Yes If yes, when? _____
List other practioners seen for this injury/condition _____
Have you ever been under chiropractic care? No Yes
If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____
Do you have health insurance? No Yes Name of company _____
* If an auto accident please provide:
Insurance company name _____ Contact person _____
Phone _____ Claim # _____

Billing Address

Name of the insured _____
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.
Patient's signature _____ Date _____
Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____. Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc).

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your symptoms interfere with daily life?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does pain wake you up at night?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are your symptoms worse during certain times of the day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do changes in weather affect your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wear orthotics?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you take vitamin supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What activities aggravate your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes

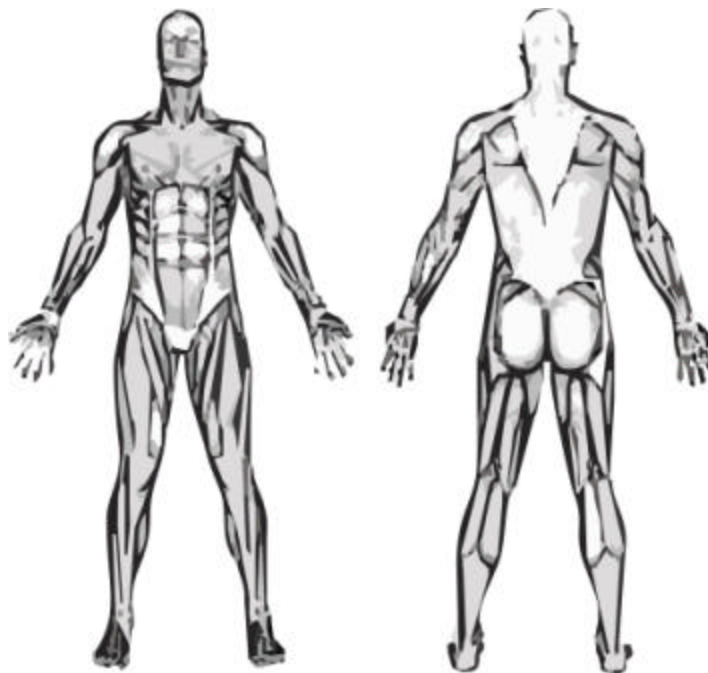
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache O=Other
 B=Burning P=Pins & Needles
 N=Numbness S=Stabbing



INFORMED CONSENT FOR TREATMENT

PATIENT NAME: _____

PATIENT FILE # _____

Physicians and other health care providers are required to obtain your informed consent before starting treatment. I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/ adjustments, physical medicine, and exercises. I understand that the manipulations / adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/ complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/ complications associated with my treatment as follows:

1. Soreness: It is common to experience muscle soreness during treatment.
2. Uncomfortableness: Temporary symptoms (dizziness, nausea) can occur, but are rare.
3. Fractures/ Joint injury: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
4. Stroke: Strokes from chiropractic adjustments are rare.
5. Burns: Some therapies used generate heat and may, in rare cases, cause burns.

Treatment results: I understand there are benefits associated with treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATIONS OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient's Signature

Witness Signature

Date

COVERAGE INFO FOR MEDICARE PATIENTS
Chiropractic Benefits are available from Medicare with limitations.

PARTICIPATING PHYSICIAN

The doctor agrees to accept assignment for Medicare covered services. The doctor will bill Medicare for covered services and accept the Medicare approved amount as payment in full. Medicare sends the payment directly to the doctor. Patients are responsible for the deductible, co-pay and services Medicare does not cover.

NON-PARTICIPATING PHYSICIAN

The doctor must follow the guidelines set by Medicare. The doctor will bill Medicare for covered services up to 80% of the limiting charge and accept Medicare approved amount as payment in full. Medicare sends the payment to the patient. Patients are responsible for the deductible, co-pay, and services Medicare does not cover.

MEDICARE COVERED SERVICES

The only chiropractic service eligible for Medicare payment is manual manipulation of the spine to correct a subluxation. There are three levels of Chiropractic Manipulative Therapy (CMT), determined by the diagnosis and number of spinal regions treated.

SERVICES THAT MEDICARE DOES NOT COVER

In order to determine the extent of your condition and type of treatment needed, the doctor will consult and examine you to arrive at a diagnosis, which may include x-ray or other tests at the clinical discretion of the doctor. Medicare requires documentation of the subluxation by exam and/or x-ray to determine the medical necessity and eligibility for payment of CMT. Medicare does not cover these types of medically necessary services performed by a chiropractor and the patient is responsible for payment of these services at the time of service. The doctor may determine and recommend physical therapy, supports, vitamins or other supplies necessary to treat your condition. Medicare does not pay any portion of these services furnished by a chiropractor and the patient is responsible for payment of these services at the time of service. Manipulation of non-spinal regions is a non-covered service by Medicare and is the patient's responsibility. Medicare does not pay for CMT considered maintenance care, and does not cover CMT considered not medically necessary.

MEDICAL NECESSITY

There are no specific treatment/visit limits on chiropractic care. The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of the subluxation within a reasonable and generally predictable period of time. The doctor will discuss treatment recommendations with the patient. Visits are screened by Medicare to determine medical necessity, and payment for services may be suspended until the treating doctor supplies additional info. Screens occur when the frequency or duration of visits exceeds the generally accepted guidelines for your diagnosis.

ADVANCE NOTICE

Medicare requires a patient be provided with written Advance Notice when a Medicare covered service may be reduced or denied for medical necessity. The patient must sign the notice each visit to accept financial responsibility for these services before they are rendered and charges incurred. If Medicare determines the visit is not medically necessary the patient is then responsible for the payment.

REVIEWS, APPEALS & HEARINGS

The doctor will submit documentation and or a statement of medical necessity to Medicare for review when payment is suspended or denied. The doctor will appeal, on the patient's behalf, denials of Medicare covered services when he disputes Medicare's determination of medical necessity or non-payment of services. The doctor may request a hearing to dispute continued non-payment upon appeal.

MEDICARE HMO

If you are a member of a Medicare HMO, there may be additional requirements for coverage such as primary care referral, in-network physician care, modification of deductible or co-pays or no coverage for chiropractic services at all. The specifics of your situation will be discussed before services are rendered.

SECONDARY INSURANCE/MEDICARE SUPPLEMENTS

Most of these types of plans only supplement payments for Medicare eligible services. The staff will attempt to verify the type of benefits you have and review this info with your. Medicare often automatically provides the info to the secondary insurance. Accurate processing of chiropractic services may require additional info.

ACKNOWLEDGEMENT

I have read and understand the explanation of chiropractic Medicare benefits outlined above. Furthermore, I understand and agree that I am personally responsible for payment of deductibles, co-payments and non-covered services.

Patient's Name _____ HIC # _____

Patient's Signature _____ Date _____

Witness _____

Patient Acknowledgment of Privacy Notice

This is to acknowledge that I _____ have been given the opportunity to review **Hollern Chiropractic, Notice of Privacy Practices.**

I understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices.**

Signature of Patient or Personal Representatives

Date