

NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date _____

Full Name: _____ Name go by if different: _____ Gender M F

Address _____ City: _____ State _____ Zip _____

Social Security #: _____ Drivers License #: _____ Birth Date: _____

Home Phone# _____ Cell Phone # _____ Email: _____

Marital Status: S M D W Employment Status: Employed F/T Student P/T Student Other

Employer _____ Occupation _____ Work Phone# _____

Spouse/Parent/Guardian _____ Age _____ Birth Date _____ SS#: _____ - _____ - _____

Employer _____ Occupation _____ Work Phone# _____

Home Phone# _____ Cell Phone # _____

In Case of an Emergency Contact: _____ Relationship: _____ Phone# _____

Name of Medical Physician _____

How did you hear about our clinic? Whom may we thank for referring you? : _____

COMPLAINT/PROBLEM: *In relation to your primary complaint:*

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N

If yes, whom? _____ Treatment(s): _____

Have you had any intolerance or reactions to treatments? Y N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Y N Same Better Gradually Worse

How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All day Few hours Minutes

Is this condition interfering with your: Work Sleep Daily routine Recreation Other: _____

How long has it been since you really felt good? Days Weeks Months Years >10 years

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____

Is there anything that you can do to relieve the problem? Y N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

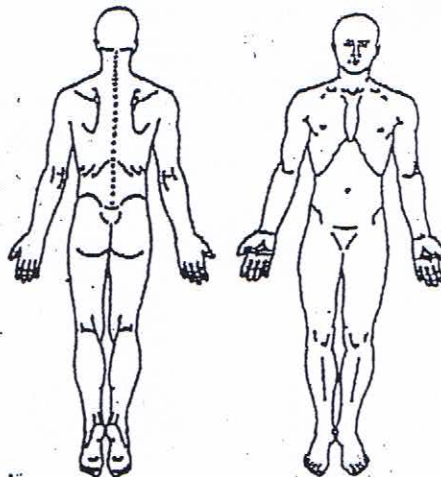
Describe: _____

Please check all of the symptoms that apply. (P=Past/ C=Current)

- | | | |
|--|---|---|
| P/C | P/C | P/C |
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Elbow/Hand Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Low Back Pain | |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Hip Pain | |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Ankle/Foot Pain | |

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

- | | |
|----------------------|--------------|
| Stabbing/Cutting-/// | Tingling-::: |
| Burning-XXX | Cramping-^^^ |
| Numbness-== | Dull-### |



Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N

SURGICAL PROCEDURES: _____

HABITS:	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	None	Type of exercise:
Alcohol	<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"/>	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Soda/Diet Soda	<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"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		64+oz	32-64oz	16-32oz	<8 oz	
					Water/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tumor(s) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcer(s) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Detached retina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke | _____ |

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

HIPPA ACKNOWLEDGEMENT

- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF Idaho Chiropractic Group, PLLC's Privacy Notice that has an effective date of June 16, 2004. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Patient Name _____ Date _____

Patient or Guardian Signature _____ Date _____



Financial Policy

Thank you for choosing Idaho Chiropractic Group, PLLC as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express. We accept assignment of insurance benefits from your insurance carrier. However, it is the patient's responsibility to ensure that the insurance carrier meets their obligations. The contract is between you and your insurance carrier. We are not a party to that contract. If your insurance has not paid the bill within 45 days, you will be asked to make a payment on the account to stay in good standing. We encourage you to contact your insurance company for any discrepancies. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Ada County, Idaho. You further understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible of those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Unless appointments are canceled at least 24 hours in advance, we reserve the right to charge for missed appointments with a \$25.00 cancellation fee. There is a fee (currently \$20.00) for any checks returned to us by the bank.

We reserve the right to charge a monthly late fee in the amount of \$5.00 for accounts past 60 days. If no payment has been made in the last 60 days from any date of service, the late fee may be applied to your account.

If you are interested in payment arrangements, a consultation can be arranged. Please contact the front desk.

INSURANCE INFORMATION:

- I have provided a copy of my insurance card (fill out portion below) I am a cash patient (no insurance)
 This will be billed to personal injury or work comp

Name of Insurance Company: _____
 Who is responsible for this account? _____ Relationship to Patient _____
 Subscribers Name: _____ Birthdate _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company named above and assign directly to Idaho Chiropractic Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Idaho Chiropractic Group may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I have read the financial policy. I understand and agree to the terms of this agreement.

Signature of Patient, Parent, Guardian, or Personal Representative

Print Name

Date

CHIROPRACTIC

CONSENT TO TREATMENT

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in the document. Please ask questions before you sign if there is anything that is unclear.

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.

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. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kleis/Dr. Matthews and have had 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 undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature