NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, would you please fill out the personal information below? If you need assistance please inform the front desk person. Thank you!

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F Marital Status: S M D

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-mail: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Guardian / Spouse / Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____ Phone #: _____

Children:

Name:	Age:	Sex: M or F	Name:	Age:	Sex: M or F
Name:	Age:	Sex: M or F	Name:	Age:	Sex: M or F
Name:	Age:	Sex: M or F	Name:	Age:	Sex: M or F

Referral Information:

- How did you find out about us _____
- Primary Care Physician (Name & Location) _____

Patient Informed Consent:

I, _____<print name>_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ **Date:** _____

CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Location:

What Is Your Primary Complaint? _____

What Caused The Onset? _____

When Did It Start? _____/_____/_____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

✓ Since the onset of your complaint how has it been changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

✓ How often do you experience this complaint? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

✓ Does your complaint worsen? If so, When? ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Other: _____

✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

✓ How much would you say this complaint has affected your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Please circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

✓ How would you describe the sensation of your complaint?

☐ Sharp pain ☐ Shooting ☐ Numbness ☐ Tingling

☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Other: _____

Modifying Factors:

✓ What makes your complaint feel worse?

☐ Coughing / Sneezing ☐ Standing ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pushing / Pulling ☐ Sitting ☐ Walking ☐ Driving ☐ Climbing ☐ Other: _____

Alleviating Factors:

✓ What makes your complaint feel better?

☐ Rest / Sleep ☐ Stretching ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pain Medication ☐ Ice ☐ Heat ☐ Shower ☐ Walking ☐ Other: _____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other: _____

Have you had Chiropractic care in the past? ☐ Yes ☐ No If so, When? ___/_____/____

Risk Factors:

Do you have a pace maker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you have any metal implants or devices? ☐ Yes ☐ No

History was obtained from: ☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Please Mark Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Allergies
X		Example	X	X	Example		X	Example	X	X	Example
		Angina / Chest Pain			Heart Problems			Seizures			Animal Dander
		Arthritis			HIV			Sleeping Problems			Latex
		Asthma			Irritability			Soreness			Food Allergies
		Back Pain			Joint Stiffness			Speaking Problems			Penicillin
		Balance Problems			Joint Swelling			Spinal Curvature			Pollen
		Broken Bones			Joint Tenderness			Stiffness			Smoke
		Cancer			Loss of Sleep			Stroke / TIA			Grasses
		Chills			Lumps			Tingling			Sulfa Drugs
		Concentration Loss			Masses			Thyroid Problems			Dairy Products
		Diabetes			Memory Loss			Tremors			Perfumes
		Dizziness			Muscle Cramps			Vertigo			Hay
		Fatigue			Muscle Pain			Weakness			Other Please List:
		Fainting			Nervousness			Other Please List:			
		Fever			Night Sweats						
		Gout			Numbness						
		Headaches			Paralysis						

Medication and Surgical History:

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken:	Yes	No	Year
Tonsils				**Women**				Insulin			
Colon				Breast				Cortisone			
Hernia				Uterus				Thyroid Medication			
Appendix				Ovaries				Male / Female Hormones			
Gall Bladder								Blood Pressure Medication			
Stomach				**Men**				Cholesterol Medication			
Heart				Prostate				Anti-Depressants			
Kidney								Tranquilizers / Sedatives			
								Birth Control			

What Other Supplements, Vitamins or Medications Are You Taking? _____

_____

_____

Injury History:

What, If Any, Major Injuries Have You Had? When? _____

_____

_____

Have You Been Hospitalized? If so, When and Why? _____

_____

_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

Social History:

✓ **What Is The Highest Level of Schooling You Have Completed?**
☐ Still in School ☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Graduate School

✓ **What Is Your Current Work Status?**
☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

✓ **How Often Do You Exercise?**
☐ Never ☐ 1-3 times per month ☐1-2 times per week ☐ 3-4 times per week ☐ daily

✓ **How Would You Rate The Intensity Of Your Exercise?**
☐ Never Exercise ☐ Low Level ☐ Moderate Level ☐ High Level ☐ Competition level

✓ **How Many Hours Do You Sleep Per Night?**
☐ <4 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 8-10 hours ☐ >10 hours

✓ **How Often Do You Eat A Balanced Diet?**
☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐ Always

✓ **How Often Do You Drink Caffeinated Beverages?**
☐ Never ☐ 1-3 Times Per Month ☐ 1-2 Times Per Week ☐ 3-4 Times Per Week ☐ Daily ☐ >2 Per Day

✓ **How Often Do You Smoke Cigarettes?**
☐ Never ☐ Past ☐ 1-3 packs per month ☐ 1-2 packs per week ☐ 3-4 packs per week ☐ >1 pack per day

✓ **How Often Do You Drink Alcohol?**
☐ Never ☐ Past ☐ 1-3 drinks per month ☐ 1-2 drinks per week ☐ 3-4 drinks per week ☐ daily

✓ **Have You Used Illicit / Street Drugs In The Past 6 Months?**
☐ Yes ☐ No

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

_____

_____

✓ **Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?**

☐ Yes ☐ No If So How:_____

Family History Information:

✓ **Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

✓ **Arthritis:**
☐Yes ☐ No Whom:_____

✓ **Back Pain:**
☐Yes ☐ No Whom:_____

✓ **Cancer:**
☐Yes ☐ No Whom:_____

✓ **Diabetes:**
☐Yes ☐ No Whom:_____

✓ **Heart Disease:**
☐Yes ☐ No Whom:_____

✓ **High Blood Pressure:**
☐ Yes ☐ No Whom:_____

✓ **High Cholesterol:**
☐ Yes ☐ No Whom:_____

✓ **Osteoporosis:**
☐ Yes ☐ No Whom:_____

✓ **Stroke:**
☐ Yes ☐ No Whom:_____

✓ **Thyroid Conditions:**
☐ Yes ☐ No Whom:_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Payment Policy:

- **Auto Accident and Workers Compensation:** If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account. Any balance billed from our office deemed 'patient responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.
- **For patients with insurance:** Clear Creek Chiropractic will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if your insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge. Payment plans are available, but you must contact our office to setup these plans. Additional Notes about insurance coverage:
    - Copays are due at the time of service.
    - You may be responsible for a Deductible Amount. This amount is deemed 'patient responsibility'. Our office will bill you for this amount following our offices receipt of an 'Explanation Of Benefits' (aka EOB) from your insurance company.
    - You may be responsible for a Coinsurance Amount. (aka % Responsibility) Our office will bill you for this amount following our offices receipt of an Explanation Of Benefits (aka EOB) from your insurance company.
    - You may choose to make payments in advance of receiving a bill for any amount considered patient responsibility.
- **For patients without insurance:** You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

Patient Name (Please Print): _____

Patient / Guardian Signature: _____ **Date:** _____