Antler Point Chiropractic Patient Questionnaire

Name_____ Date_____

Address_____ City_____ State___ Zip Code_____

Home Phone_____ Cell Phone_____

Email Address_____

Social Security_____ Date of Birth_____

How were you referred to our office? _____

Primary Physician _____ Phone Number _____

Do we have permission to contact your primary physician about your care here? Yes No

Current Employer_____ Telephone number _____

Employment status: Part Time Full Time Other

Emergency Contact & Relationship_____ Phone #_____

Health Insurance Information

Primary Insurance_____ ID#_____

Insured Persons name_____ Date of Birth_____

Secondary Insurance_____ ID#_____

Who is responsible for your Bill? You You and Spouse Workers Comp Auto Insurance

Name of person responsible if other than self

Name: _____ Phone number: _____

If your visit is related to an auto accident or work related injury:

Auto or Worker's Comp Insurance Company:_____

Date of accident or injury:_____ Claim #:_____

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Describe your Major Symptom? _____

Describe any secondary complaints? _____

Please describe WHEN and HOW this began? _____

_____

_____

How would you rate your pain? 1 2 3 4 5 6 7 8 9 10 (10 being worst)

How frequently does the pain occur? Constant Daily Comes & Goes Night Time

How long does the pain last? All Day ___ Hours ___ Minutes ___Seconds

When is the pain the worst? Upon Waking Evening As the day progresses No Change

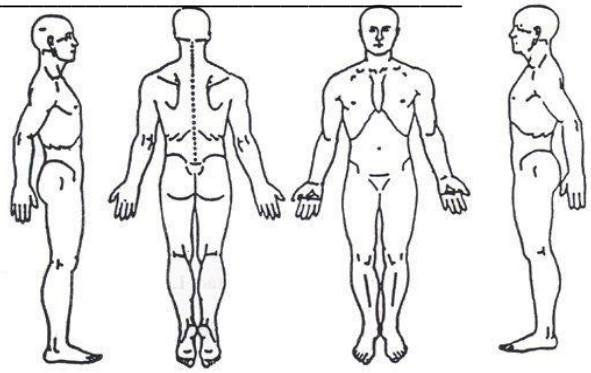
Describe the pain: Sharp /Dull/ Numb /Tingling / Aching / Burning / Stabbing / Other: _____

Does anything alleviate symptoms? Yes No Explain_____

What makes symptoms worse? Standing Sitting Lying Bending Lifting Twisting Reaching Extending Overuse Other_____

What daily activities are effected by this condition? _____

Please indicate where you are experiencing pain:



For this CURRENT condition have you:

Received any other treatment? None / Chiro / PT / MD / Massage / Acupuncture

Any Diagnostic imaging? X-rays / MRI / CT/ other: _____

Current Medications & Supplements: **NONE**

Name	Dosage	Frequency

Past Health History

Surgeries: **NONE**

Date	Area of Body	Reason

Major Injuries / Traumas / Hospitalizations:

Date	Describe

Family Health History:

List relevant major health problems in Family

Problem	Parent (M or F)	G-parent	Sibling (B or S)

Social & Occupational History

Smoking/tobacco use: Every day / Some days/ Former / Never

Habit	Frequency/Amount
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

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Review of Systems

Are you *Currently* experiencing any of these symptoms (Check all that apply)

General:
☐Recent Weight Change
☐Fever
☐Fatigue

Musculoskeletal:
☐Low back pain
☐Neck Pain
☐Pain between shoulder
☐Joint or muscle pains
☐Muscle Spasm/Cramping
☐Arm Pain
☐Leg Pain
☐Other: _____

Neurological:
☐Numbness or tingling
☐Loss of Feeling
☐Cold extremities
☐Dizziness
☐Vertigo
☐Headaches
☐Seizures
☐Tremors
☐Fainting

Mind/Stress:
☐Nervousness
☐Anxiety
☐Depression
☐Sleep problems
☐Memory Loss

Genitourinary:
☐Kidney Stones
☐Painful urination
☐Strain w/urination
☐Blood in Urine
☐Incontinence
☐Sexual difficulty

Gastrointestinal:
☐Loss of appetite
☐Nausea/vomiting
☐Frequent diarrhea
☐Constipation
☐Change in bowel movements
☐Abdominal pain
☐Hemorrhoids
☐Liver problems
☐Gall bladder problems
☐Abdominal cramping

Cardiovascular/ Heart:
☐Chest pain
☐Shortness of breath
☐Blood pressure problems
☐Irregular heartbeat
☐Swelling in hands or feet
☐Heart problems
☐Stroke

Respiratory:
☐Difficulty breathing
☐Persistent cough
☐Asthma or wheezing
☐Lung Problems

Ears, Nose, Throat:
☐Vision problems
☐Dental problems
☐Sore throat
☐Ear aches
☐Congestion
☐Hearing problems
☐Sinus problems

Endocrine, Hematologic, Lymphatic:
☐Thyroid problems
☐Diabetes
☐Excessive thirst or urination
☐Cold extremities
☐Hot/Cold intolerance
☐Dry Skin
☐Hormone imbalance
☐Anemia
☐Easily Bruise or bleed
☐Autoimmune disorder
☐Other: _____

Women Only:
Are you currently Pregnant?
☐Yes – Due Date:_____
☐No

Pregnancies:

Date	Outcome

Past Health History:
Have you been Diagnosed with any of the following?
☐Hypertension
☐Heart Disease
☐Stroke
☐ High Cholesterol
☐Kidney Disease
☐Diabetes
☐Chronic Back Pain
☐ Arthritis
☐Cancer
☐Depression
☐Multiple Sclerosis
☐Fibromyalgia

Patient ID: _____

3424 N 190th Plaza, Elkhorn, NE 68022

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, myofascial release, or cupping may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bones, muscular strains, ligament sprains, dislocations of joints, or injury to intervertebral discs, nerves, or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injuries to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few treatments. Ancillary treatment could produce skin irritation, burns, bruising, or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”. About as often as complications are seen from taking a single aspirin tablet. Cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered include the following:

- Over the counter analgesic. The risks of these medications include irritations to stomach, liver, and kidneys.
- Medically prescribed anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Remaining untreated: Delay of treatment allows formation of adhesions, scare tissues, and other changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the risks of treatment of my case explained to me. I have read and received explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have evaluated the risks and the benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date

Patient ID: _____

Antler Point Chiropractic Patient Questionnaire

Dear Patient,

Beginning on April 14, 2003, healthcare facilities are required by the Federal Government to comply with the **Healthcare Insurance Portability and Accountability Act.** This program is to protect the way your health records are stored and conveyed and dictates to whom they are revealed.

The "Notice of Privacy Practices" describes how medical information about you may be used, disclosed, and will utilized by our office. We will attempt to answer or clarify any questions or concerns that you may have, or we will put you in contact with someone who can answer your questions.

Rest assured that your privacy is and always has been a very high priority with our office. We will continue to treat you with the privacy and dignity that you deserve.

By signing below, I acknowledge that I have reviewed this notice and all my questions have been answered to my satisfaction in language that I can understand.

_____ _____

Print Name Signature

Date Signed:_____

X-Ray Examination Waiver

X-rays in this office use Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy.
If you feel that you may be pregnant, please inform Antler Point Chiropractic before your exam.

I, _____ certify that I am not pregnant and have been fully informed of the risks. If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test. I hereby release Antler Point Chiropractic & Dr. Chase Boyle DC, MS of any liability if I am pregnant at the time of this examination.

_____ _____

Signature Date

_____ _____

Witness Signature Date

Patient ID: _____

3424 N 190th Plaza, Elkhorn, NE 68022

Antler Point Chiropractic

Health Insurance:

We will call Insurance Company to verify chiropractic benefits. **All insurance companies have a disclaimer that the benefits quoted to us are NOT guarantee of payment. You are responsible to pay for any non-covered services, copays deductibles and coinsurance amounts at the time of service.** You are also responsible to contact your insurance company if you have any disagreements with how charges have been processing.

Medicare and Medicare Part B:

We accept Medicare assignment. Medicare covers only the manipulation of the spine. Medicare does have a deductible that must be met before charges are covered 100%. If you have any concerns about the deductible, please contact your insurance company. If you have Medicare supplement, please provide your insurance card at this time. After both companies have processed the claims, you are responsible for the reminder of the bill. *ABN*

Medicaid:

We participate in Nebraska Medicaid, both traditional and Primary Care Plus. You are only covered for the max visit limit per plan for year. If you have any questions about your coverage after it is ran, it is your responsibility to talk to your insurance company.

Patients without Insurance:

If you do not have insurance, don't worry! We offer an amazing $55 cash plan which includes e-stim, rehab and an adjustment. We request that 100% of all visits be paid the day of each service.

Workers Compensation:

Prior to receiving chiropractic service, you must report your injury to your employer and have authorization approved for services. You must provide the claim number, name, address and phone number of the Workers Compensation Insurance carrier. This information must be provided the day of your first appointment, or you are responsible for payment. If Workers Compensation payment is not received within three months from the date of services, or if you are suspended from or terminate chiropractic care, any fees for services are due immediately.

Personal Injury/Auto Accident:

Prior to receiving chiropractic care, it is your responsibility to provide our office with the name, phone number of your auto insurance carrier, the claim number, and complete the necessary paperwork lien. If you are in an auto accident, we also request a copy of the police report to add to your file. Although you are ultimately responsible for your bill, we will wait for settlement of your claims for up to six months from the release date of your chiropractic care, after which you are responsible for payment. Once you have released from Chiropractic care or if you are suspended from or terminate care, any fees for services are due immediately. With signed assignment, we will file all the above claims for you at no charge. If you wish to have claims go through your private insurance company first, please provide documentation of your insurance card and carrier.

Financial Policy

- ✓ **I have received and read Antler Point Chiropractic Financial Policy.**
- ✓ **I understand that Antler Point Chiropractic does not extend credit and my current balance must be paid on the day of service.**
- ✓ **I understand that my insurance benefits quoted are an arrangement between my insurance company and myself**
- ✓ **I understand my financial responsibilities at this clinic.**

Patient Name' (Print): _____

Patient Signature: _____

Parent/Guardian Signature: _____

Date: _____