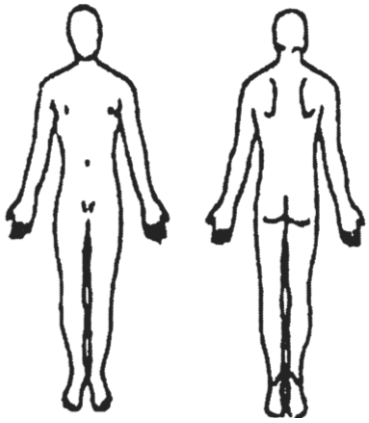
WHOLE BODY HEALTH CARE

New Patient Information

Name _____ Date _____

Complaints in order of severity:	**When did it begin?**	**Did it come on……**
1. _____	_____	Gradually Suddenly
2. _____	_____	Gradually Suddenly
3. _____	_____	Gradually Suddenly

DRAW PAIN BELOW



◯ Sharp
◯ Dull
◯ Achy
◯ Burning
◯ Throbbing
◯ Stabbing
◯ Deep
◯ Nagging
◯ Shooting
◯ Stinging
◯ Piercing
◯ Stiff
◯ Other _____

Symptom Intensity: (**For each complaint** choose the intensity *at its worst*)
No Pain 1----2----3----4----5----6----7----8----9----10 *Worst Pain*

What percentage (%) of the time you are awake does the above intensity apply?
Rarely 10----20----30----40----50----60----70----80----90----100 *Always*

Do you have radiating symptoms? • Yes • No *If yes, draw it out*

When is the pain worse?
• Morning • Afternoon • Evening • Night • No difference

What makes the symptom worse? _____

What makes the symptom better? _____

Which of the following have you tried for **this** condition? • Anti-Inflammatory Meds • Pain Medication • Muscle Relaxers
• Injections • Massage • Surgery • Physical Therapy • Chiropractic • Other _____

Medications: _____ Surgeries: _____

Accidents/other trauma: _____

Do you have a **family** history of: • Cancer • Strokes • Diabetes • Heart Disease • Adopted • Other? _____

Review of Systems *BE SURE TO CIRCLE EACH CONDITION THAT APPLIES TO YOU*

- **Respiratory** – asthma/difficulty breathing, COPD, Emphysema, other _____ NONE
- **Cardiovascular** – heart surgeries, congestive heart failure, murmurs, heart attack, heart disease, hypertension, pacemaker, chest pain, irregular heartbeat, other _____ NONE
- **Neurology** – visual changes, one-sided weakness of face/body, history of seizures, one-sided decreased feeling in face/body, headaches, memory loss, tremors, vertigo, loss of smell, strokes, other _____ NONE
- **Endocrine** - thyroid disease, hormone therapy, steroid replacement, diabetes, other _____ NONE
- **Renal –** kidney stones, blood in urine, incontinence, bladder infections, difficulty urinating, dialysis, kidney disease, other _____ NONE
- **Gastrointestinal** – nausea, difficulty swallowing, ulcerative disease, frequent abdominal pain, hiatal hernia, constipation, pancreatic disease, irritable bowel, hepatitis, bloody/black stools, vomiting blood, bowel incontinence, heartburn, other _____ NONE
- **Heme/Lymph** – anemia, regular aspirin use, HIV, abnormal bleeding/bruising, sickle-cell, enlarged lymph, hemophilia, DVT, other _____ NONE
- **Dermatology** – significant burn/rashes, skin grafts, psoriatic disorders, other _____ NONE
- **Musculoskeletal –** arthritis, gout, broken bones, spine fracture/surgery, joint surgery, scoliosis, metal implants, other _____ NONE
- **Psychology** - psychiatric diagnosis, depression, suicidal ideation, bipolar, homicidal ideation, schizophrenia, hospitalization, other _____ NONE

What are your goals for care? _____
How long do you expect it will take to meet them? _____

SEE REVERSE SIDE

WHOLE BODY
HEALTH CARE

Office Financial Policy

We invite you to discuss frankly with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient. Whole Body Health Care provides services to you, not your insurance company. Because of this fact you are responsible for payment of any bill incurred in this office. We cannot provide services assuming that the insurance company will come through with payment. As a courtesy to you we will bill your primary company for charges incurred in this office. If payment has not been made by your insurance company within 60 days, we will expect you to pay the balance in full. It will then be your responsibility to collect from your insurance company. We will also be happy to send a bill to your secondary insurance. You are responsible for all deductibles and charges not covered by your insurance. Please understand that we cannot, as a third party, become involved in any prolonged insurance negotiations. That is your responsibility. Please contact your insurance company to inquire if we are a provider for your insurance. You will also be responsible for finding out about your chiropractic coverage, visit limitations, non-covered items and deductibles.

If we treat you for injuries received in an auto or work-related accident, we would be happy to submit your claim to your insurance company. However, it is your responsibility to be in contact with your claims adjuster and make sure that your bill gets paid. You will want to make yourself aware of any PIP or visit limitations your insurance may have on your coverage. Services provided after PIP coverage/visit limitations have been exhausted will be the responsibility of the patient.

All co-payments and/or percentages that your insurance required you to pay must be paid at the time of the visit. If you do not have insurance coverage for our services payment must be made in full at the time of service unless prior arrangements have been made. We accept cash, personal checks and credit card payments.

Any account that has been left unpaid after 60 days will be charged a finance charge of 1.5% monthly (18% annually). Should collection become necessary, the responsible party agrees to pay a collection fee of 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Patient's Name: _____

Signature: _____ Date: _____

Initials _____ **I have access to read and review the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

SEE REVERSE SIDE