

HealthQuest Chiropractic & Wellness Center

www.HQwellness.com
952-448-WELL

About You

First Name: _____
Last Name: _____
Nickname: _____
Date of Birth: _____ Age: _____
Sex: () Male () Female
() Single () Married () Divorced () Widowed
() Separated
Social Security #: _____
Phone: (H) _____ (W) _____
Address: _____

E-Mail: _____
Driver's License # _____
Spouse's Name: _____

Type of work: _____
Names and Ages of Children: _____

Insurance: () Work Comp () Auto () MA
() Medicare () Private: _____
Who may we thank for referring you to our office? _____
() Yellow pages () Lecture
() Drive by () Coupon () Internet
() Screening Where?: _____
() Mailing Which one? : _____
In case of an emergency, please contact:
Name: _____
Phone #: _____

(Your social security number and your Drivers License are needed for insurance purposes only. Your information will not be shared with anyone.)

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your overall health goals? _____

Have you ever been put on a health development program? Y N
If yes, by whom? _____

Are you healthier today than you were five years ago? Y N

If yes, what have you done to improve your health? _____

Is your current condition the result of: () an auto accident? () a work related injury? () neither
Date of injury? _____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What was the duration of your care? _____

Please describe below, in the following 3 sections, your primary, secondary and additional reasons for seeking care in our office:

Primary complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? ()1-2x/week ()3-4x/week ()5-6 x/week ()daily
()other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc.)? _____

Please describe the location of the pain. _____

Does this problem cause pain or numbness to travel to any other area?: Y N If yes, where? _____

Is this problem getting: ()worse? ()better? ()staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? ()1-2x/week ()3-4x/week ()5-6 x/week ()daily
()other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc)? _____

Please describe the location of the pain. _____

Does this problem cause pain or numbness to travel to any other area?: Y N If yes, where? _____

Is this problem getting: ()worse? ()better? ()staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Additional Complaint – if any (List one. Please use the back of this page to list any other additional complaints): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? ()1-2x/week ()3-4x/week ()5-6 x/week ()daily
()other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc.)? _____

Please describe the location of the pain. _____

Does this problem cause pain or numbness to travel to any other area?: Y N If yes, where? _____

Is this problem getting: ()worse? ()better? ()staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Lifestyle/Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke cigarettes? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you drink coffee? Y N If yes, how much? _____

Do you drink tea? Y N If yes, how much? _____

How regularly do you exercise? ()daily ()____x/week ()occasionally ()never

What kind of exercise do you do? _____

How many hours of sleep do you get on average ? _____

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____

Personal _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

When was your last period? _____

Are you pregnant? ()Yes ()No ()Not sure

Family Health Profile

At our office we are not only interested in your health and well being, but also that of your family and loved ones. Please review the conditions listed below and indicate those that are current health problems of a family member by writing “**C**” under his/her column. Please write “**P**” to indicate a problem that has occurred in the past. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this page.

CONDITION	Father	Mother	Spouse	Brothers		Sisters		Children		
	Age___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___
Allergies										
Arthritis										
Asthma										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Digestive Trouble										
Disc Problem										
Emphysema										
Fatigue										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Irritability										
Kidney Trouble										
Liver Trouble										
Migraines										
Mood Swings										
Neck/Shoulder Pain										
Pinched Nerves										
Scoliosis										
Seizures										
Sinus Trouble										
Sleep Disturbances										
TMJ/Jaw Pain										
Weight Issues										
Other:										

Please list the cause of death and age of any immediate family members (parents or siblings):

Cause of death	Age at death
_____	_____
_____	_____
_____	_____

Medical History

Please check any of the following illnesses you have had:

_____ Pneumonia	_____ Mumps	_____ Influenza
_____ Rheumatic Fever	_____ Small Pox	_____ Pleurisy
_____ Polio	_____ Chicken Pox	_____ Arthritis
_____ Tuberculosis	_____ Diabetes	_____ Epilepsy
_____ Whooping Cough	_____ Cancer	_____ Mental Disorders
_____ Anemia	_____ Heart Disease	_____ Lumbago
_____ Measles	_____ Thyroid Disorder	_____ Eczema

Surgeries:

Date	Type and reason for surgery
_____	_____
_____	_____
_____	_____
_____	_____

Previous injuries or trauma (please give type and date): _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Nutritional Supplements You Are Currently Taking:

Allergies: _____

Please check any of the following you have had in the last six months:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stools
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO-VASCULAR-RESPIRATORY

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems:

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

“Protected health information” means information about you, including demographic information such as your address and phone, age, gender, etc., that may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services.

In signing this document I consent to the use or disclosure of my protected health information by Healthquest Chiropractic and Wellness Center for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the clinic. I understand that the doctors of Healthquest Chiropractic and Wellness Center may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.

The “Notice of Privacy Practices” is a document that describes the type of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, and in the performance of healthcare operations of the clinic.

In signing this document I acknowledge that I have been given a copy of the Notice of Privacy Practices and have been informed that I have the right to review the Notice prior to signing this document.

I understand that I have the right to request that the clinic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations. I understand that the clinic is not required to agree to any restrictions that I have requested, but if the clinic agrees to a requested restriction, then the restriction is binding on the clinic.

I understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that such revocation shall not apply to actions already taken by the clinic based on this consent document.

Healthquest Chiropractic and Wellness Center reserves the right to change the privacy practices described in the “Notice of Privacy Practices” document. Any revisions to the Notice will be made available to you at your request and will be posted in the reception area.

I have read and understand the foregoing notice and my questions have been answered to my full satisfaction.

Name of patient

Signature of patient/legal representative

Witness

Date Signed