Welcome

Date: _____

Patient Information

Name: _____
Last First MI

Email Address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____(W)_____(Other)_____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other:_____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Non-Hispanic/ Non-Latino

Occupation: _____ Employer:_____

Employer Address: _____Phone:_____

How did you hear about our practice?_____

Emergency Contact: Name:_____Relation:_____

Phone#:(C)_____(H)_____(W)_____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other_____

Has is been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____D.O.B :_____

Relationship to Patient (if other than self): _____ Phone#:_____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

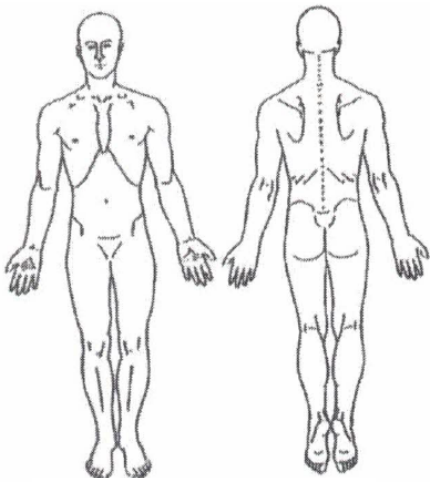
Health Questionnaire

Name:_____ **Age:**____ **DOB:**_____
Occupation:_____ **#Hours/week currently working**_____

Check off any of the following symptoms you have experienced in the past 6 months:

- ❏ Neck Pain
- ❏ Headaches
- ❏ Tension across top of shoulder
- ❏ Numbness/Tingling in arms/hands
- ❏ Carpal Tunnel
- ❏ Pain in between shoulder blade
- ❏ Difficulty Sleeping
- ❏ Allergies
- ❏ Low Back Pain
- ❏ Numbness/Tingling in legs/feet
- ❏ Pain in Legs
- ❏ Pain in Feet
- ❏ Fibromyalgia
- ❏ Tired/Fatigued
- ❏ Digestive Problems

Other: _____



(Circle areas of symptoms/pain/discomfort)

Which of the above is/are your MAJOR PROBLEM(S) and what do(es) it/they FEEL like? (Health)

1. _____
2. _____
3. _____
4. _____

How long/often have/do you find yourself suffering from this problem? (For Each)
(Constant: 100%-75%; Frequent: 75%-50%; Intermittent: 50%-25%; Occasional: 25%-1%) & (Times per week/Month)

1. _____
2. _____
3. _____
4. _____

Was there an earlier accident, injury that is directly related to this problem? (fall, auto injury, work injury, sports injury, repetitive motion on the job)

1. _____
2. _____
3. _____
4. _____

Discomfort Increases with: (Check all that apply)

❏ Movement ❏ Applied Pressure ❏ Prolonged Sitting ❏ Coughing/Sneezing
Other: _____

What have you tried that has helped this problem? (Check all that applied)

❏ Ice ❏ Heat ❏ Rest ❏ Over the counter medications ❏ Stretching ❏ Chiropractic ❏ PT ❏ Massage
Other:_____

Circle the following

Medications helped:	Little	Some	Much
Exercise helped:	Little	Some	Much
Physical Therapy helped:	Little	Some	Much
Nutrition helped:	Little	Some	Much
Chiropractic helped:	Little	Some	Much
Stretching helped:	Little	Some	Much

Has anything you have tried thus far fixed your problem? ❏ Yes ❏ No

What activities would you like to do if this was not a problem?

_____
_____

Does this issue cause you to be?

- ❏ Moody
- ❏ Irritable
- ❏ Interrupt Sleep
- ❏ Restricted in your daily activities

Does this affect your work?

- ❏ Decision making
- ❏ Poor attitude
- ❏ Decreased Productivity
- ❏ Exhausted at the end of day
- ❏ Unable to work long hours

Does this affect your life?

- ❏ Lose patience with spouse/children
- ❏ Restricted household duties
- ❏ Hinders ability to exercise/sports
- ❏ Interferes with hobbies/activities

I consent to receive a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the physician and/or clinic from any damage resulting from this demonstration.

Name:_____ Date:_____

Indiana Mandatory Disclosure and Informed Consent

300 Chiropractic and Wellness Center
122 West Main Street
Greensburg, IN 47240

This disclosure statement is in compliance with the State of Indiana, Indiana Professional Licensing Agency, Statute IC 25-2.5 and IC 25-1-9. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Indiana Professional Licensing Agency; Medical Licensing Board. If you have any comments, questions, or complaints, contact the Medical Licensing Board, 402 W. Washington Street, Room W072, Indianapolis, IN 46204, (317) 234-2060. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Medical Licensing Board in the Indiana Professional Licensing Agency.

Clinic Fee Schedule

Initial Exam/Treatment: $80.00 Subsequent Treatment: $40.00

Practitioner Education, Certification, and Experience

Dr. Breonna Reding, D.C., BS, Doctor of Chiropractic from Cleveland University, National Board of Chiropractic Examinations for Acupuncture, Acupuncture Certificate of Completion from Cleveland University, Acupuncture Certificate of Completion from National University of Health Sciences, Bachelors of Science degree in Kinesiology from Kansas State University.

Informed Consent: I hereby request and consent to the performance of acupuncture procedures by my acupuncturist. I have been informed that acupuncture is a safe method of treatment but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at the site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist. I have discussed the nature and purpose of my treatment with the acupuncturist named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of this facility. I do not expect the acupuncturist to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests. I understand that I have the choice to accept or reject treatment at any time. If you are receiving treatments from another provider for the same condition, consult your practitioner before implementing changes recommended. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition(s) and for any future condition(s) for which I seek to treat.

Signature _____ Date_____

Informed Consent To Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Gauck Chiropractic and Wellness. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time.

I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

Review of Systems

Name:_____ DOB: _____ Date:_____

Y	N	Neurological
____	____	Migraines
____	____	Headaches
____	____	Slurring of Speech
____	____	Ringing in Ear
		Ear/Nose/Throat
____	____	Altered taste/smell
____	____	Night Blindness
____	____	Sore Throat
____	____	Gingivitis
____	____	Nose bleeds
		Cardiovascular
____	____	Chest pain
____	____	Palpitations-racing heart beat
____	____	Swelling in hands/feet
____	____	Anemia
		Respiratory
____	____	Recurrent Respiratory Infections
____	____	Asthma
____	____	Chest Congestion
____	____	Wheezing
____	____	Frequent Sneezing
		GI
____	____	Stomach Pains or Cramping
____	____	Constipation
____	____	Reflux or Heartburn
____	____	Bloating
____	____	Gas
____	____	Nausea or Vomiting
		Musculoskeletal
____	____	Joint Pain
____	____	Arthritis
____	____	Chronic Pain
____	____	Muscle aches

Y	N	Skin
____	____	Eczema
____	____	Dermatitis
____	____	Excessive Sweating
____	____	Rashes
____	____	Brittle Nails
____	____	Hair Loss
____	____	Easy Bruising
____	____	Increased Bleeding
____	____	Numbness/tingling
		Genitourinary
____	____	Uterine Fibroids
____	____	Ovarian Cysts
____	____	Cancer (breast, ovarian, prostate, uterine)
____	____	Prostate Problems
		Emotional/Mental
____	____	Depression
____	____	Anxiety
____	____	Mood Swings
____	____	Irritability
____	____	Memory Loss
____	____	Confusion
		Energy
____	____	Fatigue
____	____	Hyperactivity
____	____	Restlessness
____	____	Insomnia
____	____	Decreased Libido
____	____	Stress
		Weight
____	____	Decreased Appetite
____	____	Weight Gain
____	____	Inability to Lose Weight
____	____	Food Cravings
____	____	Binge Eating
____	____	Water Retention