New Chiropractic Patient

PATIENT INFORMATION

Name: ________________________________ Birthday (M/D/Y): ___________ Age: _____ Gender: _________

Address: ____
(Street) (City) (Zip Code)

Cell: ___________________ Email: _________________________________

Check your preferred method of communication: __ Call __ Text __ Email

Occupation:___________________________________ Employer:_______________________________________

Marital status: __ Single __Married __Divorced __Widowed

Spouse's Name:________________________________ Spouse's Occupation:______________________________

# of Children: _____ Names and Ages: ____

How did you hear about us?____

Have you ever consulted a Doctor of Chiropractic? __Y __N Who?____________________ When?____________

HEALTH CONCERNS

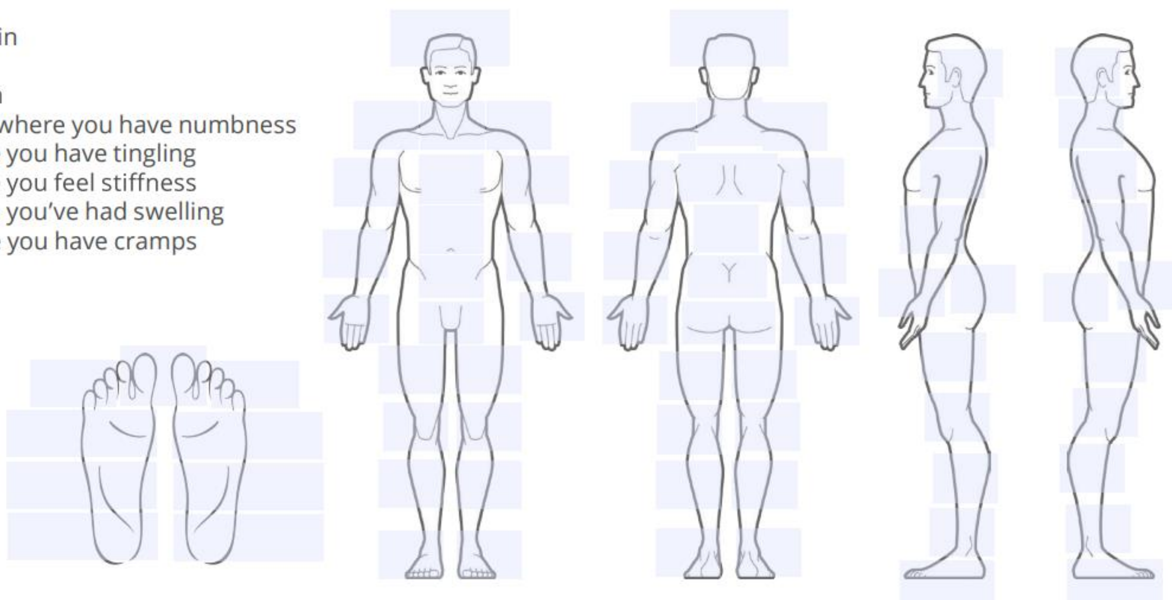
Please list, in order of importance, your health concerns:

1. ____ 3. ____

2. ____ 4. ____

Please label any areas where you are experiencing the following symptoms:

"//" stabbing pain
"B" for burning pain
"D" for dull pain
"A" for aching pain
"N" on or in areas where you have numbness
"T" in areas where you have tingling
"St" in areas where you feel stiffness
"Sw" in areas where you've had swelling
"C" In areas where you have cramps
"W" for weakness
"Tr" for tremor



PERSONAL HEALTH HISTORY

Please list hospitalizations, surgeries, major illnesses and/or medical procedures and the year they occurred.

____

____

Please list any concussions, major accidents or injuries and the year they occurred.

____

____

Do you have now or have ever suffered from:

__Headaches
__Sinus pain/Congestion
__Dizziness
__Balance/Coordination Decline
__Speech Changes
__Heart Disease
__High Blood Pressure
__Heart Palpitations or Arrhythmia
__Cancer
__Stroke
__Anemia
__Poor Circulation
__Cold/Tingling/Numbness in Hands or Feet
__Muscle Aches or Arthritis
__Frequent infections

__Skin Irritations
__Acne
__Thyroid Dysfunction
__Hormone Dysfunction
__PCOS
__Painful Breasts
__Frequent UTIs
__Menstrual Pain/Difficulty
__Kidney Stones
__Asthma
__Allergies
__Frequent Colds/URIs
__Diabetes
__Digestive Difficulty
__Heartburn
__Reflux

__Adrenal Dysfunction
__Difficulty Sleeping
__Low Energy
__Tire Easily
__Cognitive Challenges
__Concentration Challenges
__ Memory Decline
__Hyperactivity
__Restlessness
__Anxiety
__Brain Fog
__Depression
__Mood Swings
__Irritability
__Frequent Cravings
__Frequent antibiotic use

Have you ever suffered from an autoimmune condition? __Y __N Which one(s)______________________________

Please list all prescription and over-the-counter medications with dosage that you are taking and for what symptom.

If not currently on medications, please indicate that below by writing "NONE".

1. ____ 6. ____
(Name) (Symptom) (Name) (Symptom)

2. ____ 7. ____
(Name) (Symptom) (Name) (Symptom)

3. ____ 8. ____
(Name) (Symptom) (Name) (Symptom)

4. ____ 9. ____
(Name) (Symptom) (Name) (Symptom)

5. ____ 10. ____
(Name) (Symptom) (Name) (Symptom)

On a scale of 1-10, rate the stress level of your typical week ____

Please list any sources of emotional stress that are currently affecting your daily life.

____

____

DIET AND LIFESTYLE

Please describe your current diet. Are you avoiding any foods? Why?

____

____

Are you currently taking any nutritional supplements? Why are you taking these supplements?

____

____

List any real or suspected allergies/sensitivities to drugs, food, or environmental sources and your reaction.

____

____

Do you use tobacco? __Y __N Number of caffeinated beverages per day ___
Number of alcoholic beverages per week ___ How often do you work out each week?____

Name____ **DOB**: ___________________

Clinical Care Release

____ has been accepted as a patient to be seen at Innovative Health and Wellness Group.

The patient and/or his/her guardian(s), or legally responsible person(s) desire to be examined by the licensed practitioners and the clinical staff. You the patient, upon signature, give permission/consent to any clinically appropriate examination and therapeutic procedures, as determined by the clinical staff and consented to.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that providers of many disciplines may be in attendance or participate in this clinical evaluation and care process. These individuals will potentially observe all examination and treatment procedures.

Clinical staff: (Please take the time to understand the staff, their roles, and feel free to ask about scope of practice with each one). We have a multi-disciplinary staff to accommodate you.

Staff:

Elizabeth Seymour, MD

- Medical Doctor
- Clinical Director

M. Erin Van Veldhuizen, MSN, FNP-C, DC, DACNB, DCBCN, DCN, CCCN, CCTT

- Family Nurse Practitioner- Certified (Delegation with Elizabeth Seymour, MD)
- Chiropractor
- Diplomat, American Chiropractic Neurology Board
- Diplomat, Chiropractic Board of Clinical Nutrition
- Diplomat, Clinical Nutrition from American Association of Integrative Medicine
- Nutritional Therapy
- Certified Clinical Camera Thermographer, International Association of Camera Thermographers

Nisreen Tayebjee, DC

- Chiropractor
- Nutrition Therapy

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Innovative Health and Wellness Group. The procedures ordered by the staff clinicians are recommended because the potential benefits are greater than the potential risks.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient we feel we can assist in recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that neither the patient or any assigns will hold Innovative Health and Wellness Group, its staff, or its volunteers liable for any actions, non-actions, or outcomes associated with the diagnosis, treatment, and recommendations of the staff.

_________________________________ _______________________________ Date _____/______/_____
Signature of patient Printed name

____ ____________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Statement of Patient Financial Responsibility

Name: ____ DOB:________________

Innovative Health and Wellness Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies complete financial responsibility on your part.

The financial responsibility obligates you to ensure payment in full of our fees and the costs of all testing, including laboratory and other outside tests. We expect these payments at time of service.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that at no time will IHWG be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services provided should you wish to seek reimbursement independently.

While your specific treatment plan is determined by the clinical staff. The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that all costs specific to transportation, lodging, and travel expenses are to be borne by the patient and/or his/her guardian(s), or legally responsible person(s).

I have read the above policy regarding my financial responsibility to Innovative Health and Wellness Group, for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

_________________________________ _______________________________ Date _____/______/_____
Signature of patient Printed name

____ _________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Authorization to Release Information

I authorize Innovative Health and Wellness Group to release to appropriate agencies or persons, any information acquired in the course of my or the above-named patient's examination and treatment. This information may be stored and transmitted electronically using appropriate safeguards and/or data encryption.

For more information, please see the HIPAA authorization form and privacy notice, or feel free to ask a member of staff should you need clarification.

________________________________ ______________________________ Date _____/______/_____
Signature of patient Printed name

____ _________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Cancellation/No Show Policy

We acknowledge there may be times when you miss an appointment due to emergencies or obligations to work or family; however, we urge you to call 24 hours prior to canceling your appointment.

Our opportunities to treat patients are limited by our treatment regime, therefore the patient and/or his/her guardian(s), or legally responsible person(s) also acknowledge that if the patient No Shows for more than two appointments that they may be dismissed from care. The Practice will notify you if you are discharged from care.

I have read and acknowledge the above policy, and I agree to the terms described.

________________________________ ______________________________ Date _____/______/_____
Signature of patient Printed name

____ _________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Video and Photography Consent

Occasionally Innovative Health and Wellness Group will conduct filming and/or photography for promotional materials as well as for training purposes. The patient and/or their legal guardian is responsible for ensuring they are not incidentally recorded should they refuse this consent. The staff at this facility will never attempt to employ hidden or covert means to record any patient without their knowledge.

Educational Usage

In consideration that Innovative Health and Wellness Group partners with educational organizations, we request your consent to film or record various aspects of your treatment. We also request your consent to use information related to your condition or care in the training of staff and/or students. Any protected health information (PHI) will be removed or redacted from any documents used in this manner.

Promotional Usage

While relatively uncommon, we will ask to record patients for testimonials or photograph for promotional materials. General information may be shared such as a brief description of your condition, your first name and/or initials and statements you may wish to make. Should you be asked and agree to provide a testimonial, there will be no reimbursement and the product, including the rights to use your likeness, will become the sole property of IHWG.

You are free to refuse your consent to be recorded or photographed with **NO EFFECT** on your care.

I have read the above policies and wish to give my consent to:

__ Both educational and promotional usage.
__ Only educational usage.
__ None of the above.

___________________________________ ________________________________ Date _____/______/_____
Signature of patient Printed name

____ ____________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Experimental Therapy Statement

Some of the devices and therapies used at Innovative Health and Wellness Group are proprietary and/or are in the process of gaining regulatory approval. While they are thought by our clinical staff and medical advisory board to have a positive effect, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

- Compounded infusion formulas for the treatment of specific conditions.
- Various compounded medications and nutritional and dietary and supplemental usage combined with conventional medical care.

Additionally, the nutraceuticals and supplements offered may contain elements that have not been assessed by the Food and Drug Administration. While none of these, in the opinion of the clinical staff, pose an unbalanced risk or are

Inherently unsafe, we as healthcare providers feel you should be made aware that they may not have been proven effective in treating your specific condition.

I have read and acknowledge the above statement.

_______________________________ _____________________________ Date _____/______/_____

Signature of patient Printed name

____ __________________

Signature of Guardian, if patient is a minor or dependent Relationship to patient

HIPAA Authorization Form

____________________________________ _____/_____/_______ __________________

Patient's full name Date of birth Telephone number

____ ____________________

Name of legal guardian/representative (if patient is under 18) Relationship to patient

I authorize Innovative Health and Wellness Group to access, use or disclose my protected health information in the manner described below.

1) IHWG may request and be provided with a copy of prior health records, including protected health information from your current or previous healthcare provider(s).
2) IHWG may communicate with your current or previous healthcare provider(s) in reference to your diagnosis, treatment and care.
3) IHWG staff may communicate internally regarding your case.
4) You have the right to authorize or disallow communication with outside non-clinical personnel (such as a family member) regarding your diagnosis, treatment or care of IWHG.

The following information may be disclosed to, from, or between outside medical personnel and IHWG as it is relevant to your care:

*Medical Records *All treatment records

*Records regarding communicable diseases *Chiropractic records

*Alcohol/Drug abuse treatment records *Any other information relating to your condition

*Mental Health records

All past, present and future periods of healthcare information may be shared for the period of this authorization.

The purpose of the use or disclosure of this information is to facilitate effective and accurate diagnosis and treatment at IHWG, and to comply with state and federal laws.

This authorization is valid beginning on _____/_____/______ (today's date) and expires one year after the end of your care received at or from IHWG, including any follow-up care and consultations.

I acknowledge that the information used or disclosed under this authorization may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form; however, if I refuse to sign the staff of IHWG may refuse service if they are unable to gain access to previous medical records. If signed, I have the right to revoke this authorization, in writing, at any time. I acknowledge that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Please see the HIPAA privacy notice for a more detailed outline of our privacy policy.

In the event I cannot be reached, IHWG may use the following methods to communicate important health information:

___ e-mail provide the email address: ________________________________

___ voicemail at the following number (be aware work voicemails may not be secure): _____________

___ standard mail at the following address: ____

Name of any person(s) allowed to communicate with IHWG and relation to patient:

____

____

__________________________________ ________________________________ Date _____/______/_____

Signature of patient Printed name

____ ____________________

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Chiropractic Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: *The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.*

Health: *The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.*

Vertebral Subluxation: *A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, __________________________________ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

____ __________________

Signature *Date*

For All Female Patients of Child-Bearing Capability - Pregnancy Release

This is to certify that to the best of my knowledge I am NOT pregnant and Van Family Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

____ __________________

Signature *Date*

Date of last menstrual cycle: ________________________