Vanderloo Chiropractic
3731 Kimball Ave, Waterloo, IA 50702
Ph: 319-232-1143 Fax:319-232-3279

Patient Name: _____ Chief Complaint:_____

Address:_____ Cell/Home Phone: _____

City:_____ State:_____ Zip:_____ Work Phone:_____

Date of Birth:_____ Age:_____ Email: _____

Social Security #: _____ # Children____ Marital Status: S M D W

Employer:_____ Pregnant: Y N Due Date:_____

Referred by:_____ Spouse Name:_____

Spouse Date of Birth:_____ Spouse Employer:_____

****Address of Insured (if different than above):_____**

Are your present symptoms condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else may be responsible for payment?) YES NO

Family Physician: _____ (Note: We may send your health information to this provider)

Emergency Contact (Name and Phone):_____

Have you ever been under Chiropractic Care? If so, who? _____

Have you had SPINAL X-Rays/MRIs/CT taken within the last year? YES NO If so, where?_____

What operations have you had? _____ When? _____

Serious Illnesses: _____ When? _____

What medications, drugs, or supplements are you taking? (Check those that apply): Pain Killers: _____ Insulin: _____

Blood Pressure Meds: ____ Muscle Relaxers: ____ Birth Control: ____ Supplements:_____ Other: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

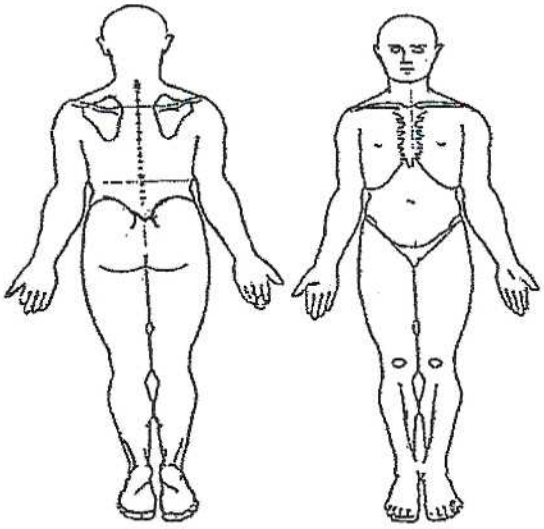
In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Vanderloo9 Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursements or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare problems involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefit claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plans any claim, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action, or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signed:_____ **Date:_____**

Patient Name:_____ Date:



What caused the pain in the shaded region to begin? _____

_____

Any previous injury to the area? Yes No

Explain: _____

When did you first notice pain? _____

Did the pain begin suddenly or gradually? Circle your choice.

Have you had this pain before? Yes No When?_____

Rate your pain on a scale from 0-10. (0 = no pain and 10 = extreme pain)

1 2 3 4 5 6 7 8 9 10

What % of the day do you notice pain (0%-100%)? _____

Describe the pain: sharp dull ache burning throbbing radiating stiffness numbness tingling

What have you found **relieves/reduces** the pain? _____

Heat Ice Topical (BioFreeze/IcyHot) Rest Exercise Massage/Stretching Medication

What have you found that **increases/worsens** pain? _____

Movement Coughing/Sneezing Computer use Bending Sit-to-Stand Transition Work

Does the pain currently or has it ever radiated to a different part of the body? YES NO If so where?_____

When during the day is the pain most noticeable? Morning Midday Afternoon Evening Night

Has the pain ever caused you to wake from sleeping at night or caused a loss of sleep? YES NO

What are the common tasks you perform at your job? _____

_____

What are your hobbies/activities you do outside of work? _____

_____

Have any of these activities/other things you enjoy been limited because of your pain? Explain.

_____

_____

Have you seen another provider for this condition?

Medical Doctor Physical Therapy Chiropractor Other_____

On average, how many hours of sleep do you get a night? _____ Are you a smoker? Y N

Do you follow a certain diet?_____ How many meals per week do you eat fast food?_____

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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures, including physical therapy, are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, or course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Vanderloo Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

To the best of my knowledge (**I am/ am NOT pregnant**) and (**give my permission/don't give my permission**) to x-ray me for diagnostic interpretation.

Due Date: _____ **Date of Last Menstrual Period:** _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communication:

In the event we would need to communicate your healthcare information to whom may we do so?

Spouse:_____

Children:_____

Others:_____

Acknowledgement

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Signed:_____ **Date:**_____

NAME:_____ DOB:_____ AGE:_____

Have you ever had? (If yes, mark and briefly describe below)

___ Cancer
(Type:_____)
___ Seizures
___ Migraines
___ Heart Attack
___ Stroke
___ Artery Disease
___ High Blood Pressure
___ Diabetes
___ Gallbladder problems
___ Ulcers
___ Heartburn/Reflux
___ Asthma
___ Emphysema/COPD
___ Pneumonia
___ Tuberculosis
___ Osteoporosis
___ Arthritis
___ Gout
___ Kidney Disease
___ Kidney Stones
___ Dialysis
___ Frequent Sinus Infection
___ Head Injury/Concussion
___ Broken Bones

Comments:

_____

_____

_____

PAST SURGICAL HISTORY: Please check mark any surgeries you have had and enter the year/age.

____ Ears
____ Tonsils/Adenoids
____ Varicose Veins
____ Intestine/Colon
____ Breast
____ C-Section
____ Sinus/Nasal Septum
____ Thyroid
____ Gallbladder
____ Hemorrhoids
____ Ovaries
____ Prostate
____ Eyes
____ Heart
____ Appendix
____ Hernia
____ Uterus/Hysterectomy

_____ SPINAL SURGERY
_____ SPINAL SURGERY (Back)
_____ ORTHOPEDIC (Foot/Knee/Hip)
_____ ORTHOPEDIC (Shoulder/Elbow/Wrist)

Comments:

_____

_____

DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING SYMPTOMS/DIAGNOSES:

GENERAL
__ Fatigue
__ Fever
__ Unintended wt gain
__ Unintended wt loss

HEENT
__ Double Vision
__ Eye Pain
__ Eye Redness
__ Decreased hearing
__ Earache
__ Ear ringing
__ Nose bleeds
__ Dry mouth
__ Oral ulcers
__ Sore throat
__ Swollen glands

RESPIRATORY
__ Chronic Cough
__ Decreased exercise tolerance
__ Difficulty breathing
__ Coughing up blood
__ Sputum production
__ Sinus pain/discharge

CARDIOVASCULAR
__ Chest pain
__ Leg pains with walking
__ Leg swelling
__ Palpitations
__ Shortness of breath

GASTROINTESTINAL
__ Abdominal pain
__ Changes in bowel habits
__ Constipation
__ Diarrhea
__ Nausea
__ Rectal bleeding
__ Difficulty swallowing

MUSCULOSKELETAL
__ Joint pain
__ Joint redness
__ Joint swelling
__ Joint stiffness
__ Muscle weakness
__ Muscle aches/pains

NEUROLOGICAL
__ Loss of bowel control
__ Dizziness/Vertigo
__ Headaches
__ Numbness/Tingling
__ Tremor

PSYCIATRIC
__ Anxiety
__ Change in sleep pattern
__ Depressions
__ Hallucinations

ENDOCRINE
__ Appetite changes
__ Cold intolerance
__ Increased thirst
__ Increased urination

HEMATOLOGY
__ Easy bruising
__ Enlarged lymph nodes

GENITOURINARY
__ Menstrual irregularities
__ Painful urination
__ Change in urinary system
__ Increased frequency
__ Blood in urine
__ Loss of bladder control

Comments:

_____

_____

_____

Notice of Privacy Practices Acknowledgement

Vanderloo Chiropractic

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (PRINT) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____