Carlsbad Chiropractic & Integrative Wellness

Date: _____

New Patient Questionnaire

Full Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

(Home Phone)_____**(Work Phone)**_____**(Cell Phone)**_____

Email Address: _____ **Social Security Number:** _____

Occupation:_____ **Employer:** _____

Sex: M F Marital Status: S M D W

Spouses Name: _____ **Occupation:** _____

Children's Name & Ages: _____

Emergency Contact Name: _____ **Phone Number:** _____ **Relationship:** _____

Favorite Hobbies & Interests: _____

How were you referred to our office? _____

Check one payment type: ( ) Cash ( ) Check ( ) Credit Card

Do you have Insurance? ( ) No ( ) Yes

Do you have Medicare? ( ) No ( ) Yes

* How would you like appointment reminders to come?
( ) EMAIL
Address: _____
( ) TEXT
Cell number: _____
(AT&T, Verizon, Sprint, T Mobile)

Insurance Company: _____

Address: _____ **State:** _____ **Zip:** _____

Policy's Holder's Full Name: _____ **Policy's Holder's Date of Birth:** _____

Your Relationship to Policy Holder: _____**Policy's Holder's SS#:** _____

Reason For This Visit:
Define the purpose of this visit:

_____

Is the purpose of this appointment related to:
( )Job ( )Sports ( )Auto ( )Fall ( )Chronic Discomfort ( )Home Injury ( )Wellness ( ) other_____
If Job related, have you made a report of your accident to your employer? ( ) Yes ( ) No
When did this condition begin?_____ Has this condition: ( ) gotten worse ( ) Stayed constant ( ) comes & goes
Does this condition interfere with: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Other Activities
Explain_____

Describe the pain…sharp, dull, throbbing, burning,etc._____
Has this condition occurred before? ( ) Yes ( ) No Explain_____
On a scale of 1-10 (1 least, 10 most), please rate the severity of your symptoms: ___/10.
Have you seen other doctors for this condition? ( ) Yes ( ) No
Dr.'s Name (s)_____
Type of Treatment_____
Results_____
Have you been to a chiropractor before? ( ) Yes ( ) No If yes, approximate date of last visit? _____

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Medications I Now Take:

( ) Nerve Pills
( ) Pain Killers (including aspirin)
( ) Muscle Relaxers
( ) Insulin
( ) Stimulants
( ) Blood thinners
( ) Tranquilizers ( )_____
( )_____ ( )_____

Health Habits:

Do you smoke? ( )No ( )Yes ___Packs/day
Do you drink coffee? ( )No ( )Yes ___Cups/day
Do you drink alcohol? ( )No ( )Yes ___Drinks/day
Do you exercise? ( )No ( ) Moderate ( ) Daily
Do you wear? ( )Heal Lifts ( ) Sole Lifts
( )Inner Soles ( ) Arch Supports
Do you take Supplements? ( )No ( )Yes
If yes, what do you take? _____

Past Injuries can affect present health. (*Please check all that apply*)

( ) Falls/Accidents ( ) Head Injuries ( ) Flights ( ) Knocked Unconscious
( ) Broken Bones ( ) Dislocations ( ) Spinal Tap ( ) Other_____
( ) Uses Cane/Walker ( ) Extensive Dental Work ( ) Sports Injuries _____
( ) Surgery(s) Please explain_____

Date of last visit with physician? _____ Name of M.D.: _____
Address: _____ Phone: _____

HEALTH CONDITIONS:

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and being accepted for care.

( ) Severe or Frequent headaches
( ) Sinus Problems
( ) Dizziness
( ) Loss of Sleep
( ) Pain Between the Shoulders
( ) Frequent Neck Pain
( ) Numbness or Pain in Arms/Legs/Hands
( ) Lower Back Problems
( ) Digestive Problems
( ) Ulcers/Colitis
( ) Heart Attack/Stroke
( ) Congenital Heart Defect
( ) Heart Surgery/Pacemaker
( ) Heart Murmur
( ) High/Low Blood Pressure
( ) Thyroid Problems
( ) Allergies, To what?_____
( ) Fibromyalgia
( ) Others Not Listed above _____

( ) Asthma
( ) Arthritis
( ) Alcohol/Drug Abuse
( ) Venereal Disease
( ) HIV/AIDS
( ) Diabetes, type1 or 2
( ) Tuberculosis
( ) Shingles
( ) Kidney Problems
( ) Hepatitis
( ) Cancer
( ) Chemotherapy
( ) Anemia
( ) Rheumatic Fever
( ) Psychiatric Problems
( ) Depression
( ) Osteoporosis
( ) Jaw Pain

For Women:

Are you Pregnant? ( ) yes ( ) no
Are you nursing? ( ) yes ( ) no
Are you taking Birth control? ( ) yes ( ) no
Do you experience painful periods? ( ) yes ( ) no
Do you have irregular cycles? ( ) yes ( ) no
Do you have breast implants? ( ) yes ( ) no

Are there other health concerns or anything else you would like us to know about you? Please tell us.

The above is accurate to the best of my knowledge.

_____ _____
Signature of patient (or guardian) Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operation, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written request consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and the health care operations our office has the right to refuse to give care.

The HIPPA compliance officer for Chiropractic and Therapy Center of Carlsbad is Mayra.

Patient Health Information Consent Form Acknowledgement of Receipt

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Name:_____

Patient Signature_____Date:_____

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CONSENT TO TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize Jason Higgins, D.C., Brittany Watson, D.C., Katrina Karnes & Tracy Hewitt, LMT, to examine and treat me. I hereby request and consent to the performance of procedures, which may include but is not limited to various modes of physical therapy, diagnostic x-rays, chiropractic adjustments, massage therapy, or nutritional supplement recommendations, on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or other licensed doctors who now or in the future treat me while employed by, working, or associated with or serving as back up for the above mentioned doctors and Carlsbad Chiropractic & Integrative Wellness.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I request that payment of authorized benefits be made either to me or on my behalf to the above mentioned doctors for any services furnished to me by that doctor. I authorize any insurance company or any government agency and its agents any information needed to determine these benefits or the benefits payable for related services. I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that 1 am liable for all charges for services rendered and 1 agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that verification of insurance benefits is not a guarantee of payment. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all medical information necessary to secure payment, including copies of chart notes.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. If the patient is a minor, who is the responsible party for?

TO BE COMPLETED BY PATIENT

Patient's Name: _____ Signature of Patient: _____

Date Signed: _____ Witness or Patient's Guardian Signature: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name: _____ Signature of Patient: _____

Date Signed: _____ Representative's Signature: _____

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CANCELLATION POLICY

Our goal is to provide quality individualized chiropractic care in a timely manner. "No shows", and late cancellations inconvenience those individuals who need access to care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for those in need of care.

Chiropractic & Therapy Center of Carlsbad is committed to offering the best service to everyone who needs our services, and we commit the best resources available to your appointment. Therefore, we require a **minimum of 24-hour cancellation notice for massages and at least 2-hour cancellation notice for chiropractic appointments.**

For massage – "No show"/late cancellations will be billed for half of the price of the first appointment, then 100% of the appointment for any subsequent missed appointments.

For chiropractic – "No shows"/late cancellations will be billed $30. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

As always we will try out best to give you a courtesy reminder about your appointment via email or text, however, it is your responsibility to remember your appointment once you have made it.

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