

BLAU FAMILY CHIROPRACTIC

641 Latton Lane, Portage, WI 53901
(608) 742-1300 www.blauchiropractic.com

Please fill out this form as completely and accurately as possible.

Today's Date _____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Parents' names (if you are under 18) _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Cell Phone (_____) _____ E-Mail Address _____

Occupation _____ Employer _____

Marital Status S M D W Spouse/Partner's Name _____

Gender M F Preferred Language _____ Race _____ Ethnicity _____

Names and ages of children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Blau Family Chiropractic can address for you?

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work Y N Driving Y N Sleep Y N

School Y N Walking Y N Sitting Y N

Exercise/Sports Y N Eating Y N Other Y N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N Name of D.C. _____

How long under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why did you stop? _____

Who is your family Physician? _____

How was your experience? _____

Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

Medical Physician Naturopath Acupuncturist Homeopath

Massage Therapist Psychotherapist Energy Healer Dentist

Reason why: _____

FOR WOMEN ONLY

Are you pregnant? Y N Possible/Unknown

If pregnant due date? _____ Name of OBGYN or Midwife _____

If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.

Signature: _____ Date: _____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and *how they may relate to your present spinal, nerve and health status.*

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

Does your job require regular airline travel and hotel stays? Y N If yes, how often? _____

How long is your daily commute? _____ How many hours do you typically work in a week? _____

How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____

Please describe your exercise/sports program including type and frequency:

How many hours of sleep do you typically get each night? _____ Do you sleep well? Y N

Do you ever sleep on your stomach? Y N How old is your mattress? _____

Do you wear orthotics (foot supports) or a heel lift? Y N If yes, for how many years? _____

Do you use a cervical pillow? Y N

PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? Y N C-section? Y N Forceps/Vaccum ? Y N

Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

Have you had any **significant adult injuries**? Please list dates, injury and treatment: _____

Have you had any **automobile accidents or work-related injuries**?

Date: _____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: _____ Care received: _____

Date: _____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: _____ Care received: _____

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of loved one	<input type="checkbox"/> Y <input type="checkbox"/> N	Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N
Work or school	<input type="checkbox"/> Y <input type="checkbox"/> N	Divorce/separation	<input type="checkbox"/> Y <input type="checkbox"/> N	Financial	<input type="checkbox"/> Y <input type="checkbox"/> N
Lifestyle change	<input type="checkbox"/> Y <input type="checkbox"/> N	Parents divorce	<input type="checkbox"/> Y <input type="checkbox"/> N	Illness	<input type="checkbox"/> Y <input type="checkbox"/> N

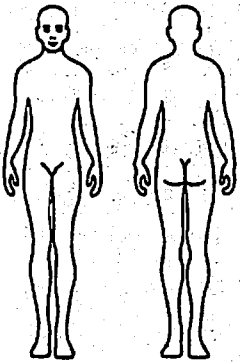
CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Curvature <input type="checkbox"/> Mental / Emotional Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Swollen or Painful Joints <input type="checkbox"/> Skin Problems <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Upper Back Pain / Stiffness <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Constipation / Diarrhea <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Menstrual Problems / PMS <input type="checkbox"/> Menopausal problems <input type="checkbox"/> Convulsions / Epilepsy in arms, or hands R/L | <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Neck Pain R/L <input type="checkbox"/> Shoulder Pain R/L <input type="checkbox"/> Numbness or Tingling <input type="checkbox"/> Carpal Tunnel Syndrome R/L <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Depression <input type="checkbox"/> Attention Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Loss of memory legs or feet R/L <input type="checkbox"/> Ear Infection <input type="checkbox"/> Learning Disability | <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficult Breathing <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heart Attack <input type="checkbox"/> Bruit <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Mid Back Pain / Stiffness <input type="checkbox"/> Pain with cough, or strain <input type="checkbox"/> Hip Pain <input type="checkbox"/> Low Back Pain / Stiffness <input type="checkbox"/> Sciatica <input type="checkbox"/> Numbness or Tingling in <input type="checkbox"/> Stroke <input type="checkbox"/> Muscle Tightness <input type="checkbox"/> Trouble sleeping |
|--|--|--|

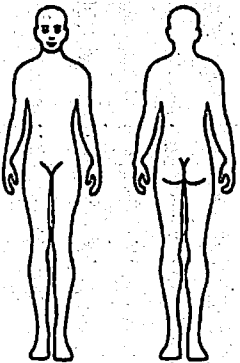
Primary Health Concern: _____



- o Please indicate the location of your pain or discomfort on the diagram
- o When did this problem start? _____
- o Have you ever had this problem before? No Yes If yes, when _____
- o Please indicate quality of the pain:
| Dull | Burning | Numb | Stabbing | Tingling | Cramping
- o Does this pain radiate or travel? No Yes If yes, please indicate on diagram
- o Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- o What makes this pain or condition better? _____ Worse? _____
- o What have you done to treat this problem? _____

Office Use Only:

Secondary Health Concern: _____



- o Please indicate the location of your pain or discomfort on the diagram
- o When did this problem start? _____
- o Have you ever had this problem before? No Yes If yes, when _____
- o Please indicate quality of the pain:
| Dull | Burning | Numb | Stabbing | Tingling | Cramping
- o Does this pain radiate or travel? No Yes If yes, please indicate on diagram
- o Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- o What makes this pain or condition better? _____ Worse? _____
- o What have you done to treat this problem? _____

Office Use Only:

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.)

The following will reveal exposures you may have had.

Were you **vaccinated**? Y N If yes, did you have a **reaction**? Y N

Have you been **exposed** to any of the following on a regular basis, past or present?

Toxic chemicals Radiation Second hand smoke Chemotherapy Drug therapy Other

If yes, please explain: _____

Do you have any **food allergies**? Y N If yes, please list: _____

How many **fast food meals** do you eat per week? _____

How many **alcoholic beverages** do you drink per week? _____

Do you smoke **tobacco products**? Y N If yes, how many packets per day? _____

How many glasses of **water** do you drink per day? _____

How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____

Are you currently on **prescription** or **over-the counter medication**? Y N Please list, indicating dose & frequency _____

Please list any **nutritional supplements** you are taking: _____

QUALITY OF LIFE

How do you rate your **emotional/mental health**? Excellent Good Fair Poor

How do you rate your overall "**quality of life**"? Excellent Good Fair Poor

How do you rate your **physical health**? Excellent Good Fair Poor

How would you rate your **overall health**? Excellent Good Fair Poor

EXPECTATIONS

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- Relief of a symptom or problem
- Relief and prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health on all levels

What are your top three health goals?

1. _____
2. _____
3. _____

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ Date: _____

Office Fee Schedule and Financial Policy

Services

Consultation	N/C
Initial Exam/Computer Scans	\$80
Dynamic Exam/Computer Scans	\$75
X-Rays (per view)	\$50
Adjustment	\$60
Light Therapy	\$25
Vibration Therapy	\$30/15min
Nutrition Consultation	\$45/30min
Pettibon/Rehab	\$30/15min
Wellness Adjustment Plans	Varies per persons needs

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service, unless you are participating in a Care Plan. These Care Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report. Balances with no payment over 30 days will be charged a \$5.00 statement fee, this charge will occur each month until arrangements have been made or balance is paid in full. Patient balances over 60 days will be forwarded to a collection agency with any accrued interest.

- Cash Policy: Payment is due at time of service or according to the plan of your choice.**

- Health Insurance:** If you have Insurance that covers chiropractic care, we will send in your claims for you. Deductibles and co-pays are paid at time of service, or paid according to the plan of your choice. Remember, **your agreement with your insurance company is between you and them.** Please submit any requested information to them as quickly as possible. Any balance due to denied or reduced claims will be **your responsibility.** Having Insurance does not always guarantee payment.

If you acquire insurance for a special situation such as an auto accident or worker's compensation please let us know immediately. Once a claim is complete, you can return to your original Care Plan.
I have read and I understand the above policies. I have checked the one that applies to me.

Patient Signature

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Blau Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, light therapy, Pettibon, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Other treatment options that could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.

Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or Questions

Please ask your Doctor of Chiropractic. Be assured Blau Family Chiropractic has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of Chiropractic Treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

Date

Signature of Patient or Parent

Printed Patient Name

Notice of Information Practices

Protecting the privacy of your health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operation will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you for up to 7 years.

In the future, we may contact you for appointment reminders, missed appointments, announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

I _____ have read and understand this notice.

_____ Phone Number _____ Date _____

Signature

The effective date of this Notice of Information Practices is 10/02/2006.

Blau Family Chiropractic * 641 Latton Lane * Portage, WI 53901 * 608-742-1300*
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