Wellspring Chiropractic and Acupuncture Center
New Patient Data Form

Patient Data **Date**

First Name _____ **Middle Initial** ____ **Last Name** _____

Preferred nickname_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____**)** _____-_____ **Work Phone (**_____**)** _____-_____

Cell Phone (_____**)** _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Spouse Data

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (_____**)** _____-_____ **Work Phone (**_____**)** _____-_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

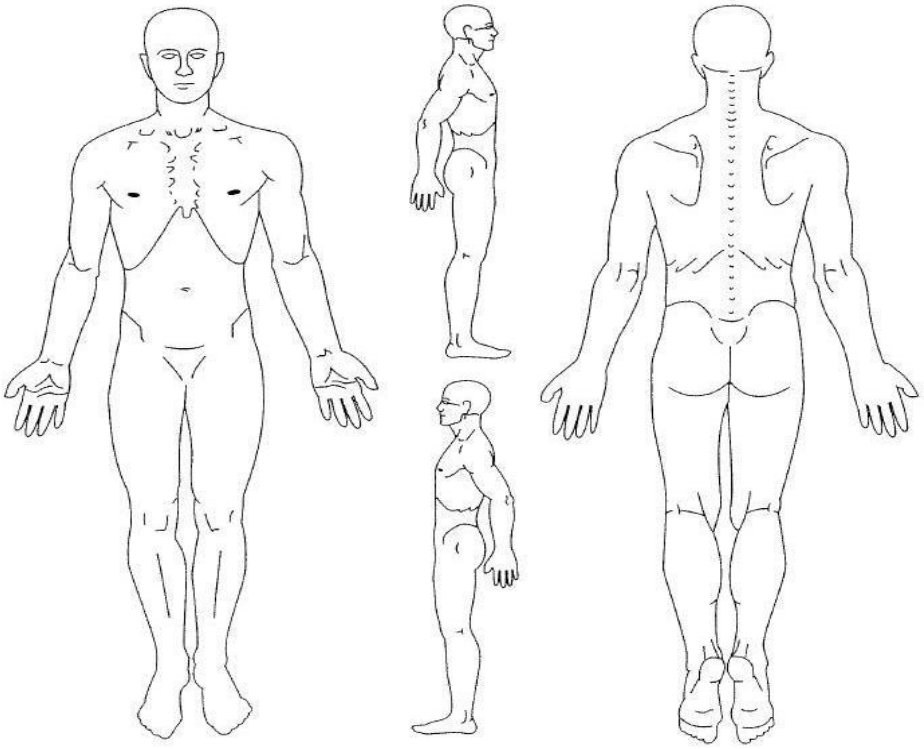
Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____**)** _____-_____ **Cell Phone (**_____**)** _____-_____

How did you hear about our office? _____

Patient Name_____**Birthdate**_____

Have you had a recent accident or injury? Yes_____ No _____ Describe _____
By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Symptom 1_____
Severity
None Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10
Frequency
Never On&Off Constant
0 1 2 3 4 5 6 7 8 9 10

Symptom 2_____
Severity
None Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10
Frequency
Never On&Off Constant
0 1 2 3 4 5 6 7 8 9 10

Symptom 3_____
Severity
None Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10
Frequency
Never On&Off Constant
0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms:
_____
_____
_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____
Symptoms began ☐ **Gradually** ☐ **Suddenly**
When did your symptoms begin? Month_____ Day_____Year _____

Describe how your symptoms began? _____
_____

What describes the nature of your symptoms?
□ Sharp □ Dull ache □ Numb □ Shooting
□ Burning □ Tingling □ Stabbing □ Other _____

How are your symptoms changing?
□ Getting better □ Not changing □ Getting worse

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have your symptoms interfered with your daily activities (Work/Sleep/Exercise/ Self care)?_____
_____

Are you pregnant? Yes_____ No _____N/A_____ If Yes, how many weeks? _____

Patient Name_____**Date**_____

Medical History

Medical Conditions: (Check all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Tuberculosis	□ Hepatitis A, B, or C	□ Kidney Disease	□ Anemia
□ Headaches	□ Epilepsy, seizures	□ Addiction	

□ Other _____

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia

□ Other _____

Allergies to Foods and Medications: (Check all that apply to you)

□ Eggs	□ Fish and Shellfish	□ Milk or Lactose	□ Peanuts
□ Soy	□ Sulfites	□ Wheat/Glutens	□ Other _____

Social History: (Check all that apply to you)

Cigarettes:	# packs/day_____ # of years_____				never	quit date_____
Chew Tobacco:	daily	occasional	often	rarely	□never	amount/day_____
Caffeine use:	daily	occasional	often	rarely	□never	# cups/day_____
Sugar intake:	daily	occasional	often	rarely	□never	#servings/week_____
Drink Alcohol:	daily	occasional	often	rarely	□never	# drinks/week_____
Exercise:	daily	occasional	often	rarely	□never	
Wear Seat Belts:	daily	occasional	often	rarely	□never	

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Please list all Medications:

Medication	Dose	Condition

Occupational Activities: (Check one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper

□ Other _____

Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, check NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please describe any major trauma, hospitalizations, motor vehicle accidents or surgical procedures:

_____

_____

_____

_____

Patient Name_____Date_____

Payment/Insurance Information:

You are responsible for payment of services at the time they are rendered. If you wish to self file your insurance to be reimbursed, please provide us with your information below.

Personal Health Insurance Carrier: _____Insurance. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____________Date_____

Consent to Treat:

I acknowledge that I have received and /or have been given the opportunity to review the informed consent statement for this office including risks, benefits, and alternatives to treatment. By signing below, I do herby voluntarily consent to be treated with Acupuncture and or/ Chiropractic and associated modalities by our practitioners, Dr. Bonnie L Walker and Dr. Amanda Peters.

Print Patient's Name _____

Patient's Signature _____________Date_____

Wellspring Chiropractic and Acupuncture Center
Financial Policy

- Payment is expected at time services are rendered unless a signed financial agreement has been prepared in advance.

- We realize that health needs do not always coincide with financial means. When your treatment requires several visits, we will be happy to give you an estimate of the total treatment length and the approximate costs (Report of Findings). If you have a special situation or need, please let us know and we will tailor a payment plan designed for your unique circumstances. Please speak to the business manager. New patient visits must be paid in full at time of service.

- All supplements and supplies must be paid for in full at the time they are dispensed. This is over and above any financial arrangement with the business office.

- We do not accept insurance assignment. We can prove you with a form to file your own insurance, reimbursement should come directly to you, and negotiations with insurance company are the responsibility of the patient.

- We are not participating providers for insurance plans other than Medicare. If you are wishing to use Medicare for treatment please ask the front desk for additional information.

- We do not accept Workman Compensation, Personal Injury (PI) or auto accident cases on contract with insurance companies.

- Any appointments that are cancelled without 24 hours' notice may be charged a $50.00 missed appointment fee.

- Payment for services may be made by cash, check, Visa, Discover and MasterCard.

I HAVE READ THE ABOVE AND AGREE TO THESE FINANCIAL TERMS.

(Patient or Responsible Party)

Name _____

Signature _____Date_____