NEW PATIENT QUESTIONNAIRE

Patient Name: ______________________________ **DOB:** ____________________

Gender: M F **Marital Status:** S P M D W **# Children:** ______________

Please circle your current health condition: Critical Poor Average Good Great

Medical / Surgical History

Please circle any current or previously diagnosed medical conditions:

Alcoholism	Glaucoma	Osteoporosis
Allergies	Heart Disease	Pregnancy
Anemia	Headaches/Migraines	Psychological
Arthritis	Hepatitis/Liver Disease	Reproductive
Asthma/Emphysema	High Blood Pressure	Respiratory
Broken Bones	High Cholesterol	Seizures
Cancer ____________	Hormone Imbalance	Skin Condition ____________
Cardiovascular ________	Immune System ________	Stress
Cataracts	Inflammation	Stroke/TIA
Depression	Low Blood Pressure	Swelling
Diabetes	Menstrual	Thyroid Disorder
Dietary Problems	Muscular ____________	Urinary
Endocrine/Glands ______	Nervous System ________	Varicose Veins
Fibromyalgia	Numbness/Tingling	Other ________________

Do you have any communicable diseases? ____

Please circle any allergies and describe their associated reactions:

Food ________________ Latex ________________ Medications ________________

Animals ______________ Plants ________________ Other ____________________

Please list any past surgeries/dates:

____

____

Please list any vitamins/supplements/herbs:

____

____

Please list all prescription medications you are currently taking and their doses: ________________

____

Office Use Only: Provider signature for LMT/LAc:____________________________________

Patient Name: ______________________________ **Date of Birth:** ____________________

Please circle if you have experienced any of the following during the past year:

Personal Illness or Injury	Major Illness or Death in Family	Death of a Close Friend
Change of Residence	Loss of a Job	Divorce or Separation
Retirement	Loss of a Pet	Marriage

Family Health History

Please circle the condition a family member has and indicate the relationship:

Diabetes ____________	Cancer ____________	High Blood Pressure ____________
Depression ____________	Suicide ____________	High Cholesterol ____________
Heart Attack ____________	Stroke ____________	Alcoholism ____________
Thyroid Disease ____________	Other ____________	

Current Health History

Please circle any conditions you currently have or had in the past:

Vision or Eye Changes	Autoimmune Condition	Loss of Libido
Trouble Swallowing or Heartburn	Back, Joint or Muscle Pain	Problems with your Feet
Lost or Gained 10 Pounds Recently	Difficulty Urinating/Holding Urine	Swelling of Ankles/Feet
Shortness of Breath/Coughing Fits	Frequent or Intermittent Dizziness	Difficulty Sleeping
Chest Pain or Heaviness with Activity	Severe Headaches/Migraines	Suffered Any Recent Falls
Recent Change in Bowel Movements	Tire Easily or Exhaustion	Hearing or Ear Conditions

For Women Only: Abnormal Vaginal or Menstrual Bleeding Taking Birth Control or Estrogen

For Men and Women: Breast Lumps or Nipple Discharge Do a Monthly Breast Exam

Do you eat a special diet?	Yes	No	Description: ____________________
Do you exercise regularly?	Yes	No	How often: ____________________
Do you chew tobacco?	Yes	No	How often: ____________________
Do you drink alcohol?	Yes	No	How much: ____________________
Do you drink caffeine?	Yes	No	How much: ____________________

(Caffeine is in soda, energy drinks, tea, coffee, and many other products.)

Patient Name: ______________________________________ **Date of Birth:** ____________________

Please answer the following questions regarding your appointment today:

Is today's visit due to a major vehicle crash? Yes No

Is today's visit due to an on the job injury? Yes No

Have you ever been to a chiropractor before? Yes No

If yes, when? ______________ What for? ____

Have you had recent x-rays taken? Yes No

If yes, when? ______________ Where? ____

What areas were imaged? ____

Your Primary Physician: _______________________ Your Last Physical Exam: _______________________

Do you wear? Heel Lifts inner Soles Arch Supports Negative Heels Platforms

Date your current symptoms appeared: ____

Indicate Where You Are Hurt

Indicate using the symbol key the areas of your body where you are feeling symptoms. If you are experiencing pain that radiates, please use an arrow to indicate where it begins and ends.

Ache	Numbness	Pins & Needles
<<<<<	·····	**ooooo**
Burning	**Stabbing**	**Throbbing**
xxxxx	/////	~~~~~

1. What is your symptom intensity right now?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

2. What is your typical or average symptom?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

3. What is your symptom intensity at its worst?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

4. How often are your symptoms present?
0 - 25% 26 - 50% 51 - 75% 76 - 100%

5. How much do your symptoms interfere with your daily activities?
0 1 2 3 4 5 6 7 8 9 10
None *Unable to Perform*

Doctor's Initials __________ Date ___________

SIGNATURES for OFFICE POLICIES

________ I understand that if I have any prosthetics or surgical implants (including breast implants, artificial joint(s), etc.), I should discuss this with the practitioner providing me care.

________ I understand that I play an important role in my own healthcare. Just as a patient can choose to discontinue care at any time, Blyss Chiropractic and it's independent contractors (Aaron Annis, LAc/ Sattva Health Gallery and Shay Law, LMT, LLC) reserve the right to terminate a practitioner/patient relationship if a patient is continually unable to comply with a reasonable treatment plan by repeatedly missing scheduled appointments, or if inappropriate behaviors are directed at others within the clinic.

________ **Cancellation and Bounced Check Policy:** I understand there is a $25 charge for missing appointments beyond 3 that have not had 24 hour advanced notice for cancellation. I also understand there is an additional $30 charge for all returned checks (non-sufficient funds).

________ Occasionally, this clinic participates in internships/observation opportunities for chiropractic students. This student may be present in the treatment room during your office visit. You may request privacy at any time or chose NOT to participate at all by leaving this space blank.

PATIENT ACKNOWLEDGMENT OF RISK AND CONSENT TO TREAT

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided to me within this medical office. I have read and understand the statements regarding risks, treatments, and the possible complications thereof and understand **that there is no guarantee or warranty for a specific cure or result.**

Patient Signature: ____ Date: ______________________

PATIENT ACKNOWLEDGMENT OF PRIVACY POLICY

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided to me within this medical office by associates and/or independent contractors.

Patient Signature: ____ Date: ______________________

PATIENT ACKNOWLEDGMENT OF OFFICE POLICY AND FINANCIAL AGREEMENT

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided to me within this medical office, including those rendered by independent contractors. I further acknowledge that based on the this information I am fully responsible for the payment of the services provided and authorize my insurance benefits to be paid directly to Blyss Chiropractic, Aaron Annis, LAc/Sattva Health Gallery, and Shay Law, LMT, LLC. I understand and agree to all of the said applicable responsibilities, policies, and risks.

Patient Signature: ____ Date: ______________________

PATIENT REGISTRATION

Effective Jan.1, 2013 all health care clinics are required to have the following information on file. Please complete all sections.

Last Name: ______________________________ **First Name:** ______________________________ **MI:** ________

Date of Birth: ________________ **Gender:** Male Female **Weight:** _________ **Height:** ___________

Marital Status: Single Married Other **Preferred Language:** English Other: ___________

Do You Smoke: Current Former Never **Frequency:** (per day) 1-5 1/2 Pack 1 Pack 2+ Packs

Race: Asian African American White Other: ____

Ethnicity: Decline to Disclose Non-Hispanic Hispanic Mexican Puerto Rican Unknown

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Address: ____ **Apt #:** _______________________

City: ____ **State:** ___________ **Zip:** ___________________

Cell Phone: ____ **Home Phone:** ______________________________

Email Address: ____

We now offer phone or email reminders, please circle which method you prefer: Cell Home Email

Please let us know how you found out about our Clinic: ____

Employment: Full Time Part Time Student Unemployed Retired Other: ___________________

Company Name: ____

Job Title: ____

Work Phone: ____ **Ext:** _______________________

☐ Please check this box if you *do not* want to be contacted at work.

Emergency Contact: ____
(Must be a family member or someone able to make medical decisions on your behalf in the event of a medical emergency.)

Relationship to Patient: ____

Cell Phone: ____________________________________ **Home Phone:** ___________________________________

Health Insurance Verification Form

☐ Checked Benefits Online

Phone #: ______________________ Reference / Rep.: ______________________

☐ NEW PATIENT
☐ RELATED TO MOTOR VEHICLE CRASH

☐ PRIMARY
☐ SECONDARY

Name as it appears on insurance card: ______________________ DOB: ____________ ☐ SELF
Subscriber (if different from above): ______________________ DOB: ____________ ☐ SPOUSE ☐ CHILD ☐ OTHER: ________

Ins. Provider: ______________________ ID # (include any letters) ______________________

Group Name: ______________________ Group # ______________________

Active: Y ☐ N ☐

Effective Date: ____________
☐ Calendar Year ☐ Plan Year Deductible: $__________ Remaining: $__________

Chiropractic
Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: ______ Co-Ins: __________%

Number of Visits/Yearly Maximum Dollar Amount: __________ Used: ______ Combined: Acupuncture / Massage / Physical Therapy

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Physical Therapy
Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: ______ Co-Ins: __________%

Number of Visits/Yearly Maximum Dollar Amount: __________ Used: ______ Combined: Acupuncture / Massage / Chiropractic

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Acupuncture
Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: ______ Co-Ins: __________%

Number of Visits/Yearly Maximum Dollar Amount: __________ Used: ______ Combined: Chiropractic/ Massage / Physical Therapy

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Massage

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: ______ Co-Ins: __________%

Number of Visits/Yearly Maximum Dollar Amount: __________ Used: ______ Combined: Chiropractic/ Acupuncture/ Physical Therapy

Common Health Insurance Terms and Definitions

Allowed Amount – The highest amount that your insurance will cover (pay) for a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans, however many plans run on a plan year, meaning coverage starts on a date other than January 1st and ends on a date other than December 31st.
Example: You may have a plan with a benefit period of January 1st through December 3st that covers 10 physical therapy visits. The 11th or more session will not be covered.

Claim—A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

Coinsurance—The amount you pay for a covered service after your deductible has been met. The coinsurance rate is usually a percentage.
Example: If the insurance company pays 80% of the claim, you pay 20%.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Deductible—The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying. **Premiums do not count toward your deductible. Copays may or may not count toward your deductible.**

Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will either cover all of your remaining costs for covered services in that benefit year, or a percentage of the rest of your costs until you have met your out of pocket maximum.

Dependent—Any individual, either spouse or child, who is covered by the primary insured member's plan.

Effective Date—The date on which a policyholder's coverage begins.

Exclusion/Limitation/Non-Covered Services—Any specific situation, condition, or treatment that a health insurance plan does not cover.

Explanation of Benefits (EOB)—The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Group Health Insurance—A coverage plan offered by an employer or other organization that covers the individuals in that group and their dependents under a single policy.

In-Network Provider—A health care professional, hospital, or pharmacy who is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers.

Individual Health Insurance—Health insurance plans purchased by individuals to cover themselves and their families. This is different from group plans, which are offered by employers to cover all of their employees.

Network—The group of doctors, hospitals, and other health care providers who insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.

Out-of-Network Provider—A health care professional, hospital, or pharmacy who is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

Out-of-Pocket Maximum—The most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Once you have paid this amount, the insurance company will pay all expenses for the remainder of the year, with the exception of your monthly premium.

Payer—The health insurance company whose plan pays to help cover the cost of your care. Also known as a Carrier. (Examples: Blue Cross Blue Shield, Moda, Kaiser, etc.)

Premium—The amount you or your employer pays each month to your insurance provider to keep your coverage. The payments are due at specific times.

Provider—Any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) who provides medical care.