GONSTEAD
CLINIC OF CHIROPRACTIC

1505 Business Hwy 18-151
PO Box 46, Mt. Horeb, WI 53572
608-437-5585
www.gonsteadmthoreb.com

Doctor______________

Date________________

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Full Name ____ **E-mail:**_________________________________
Address ____
(Residence and mailing) (City) (State) (Zip)
Phone No. (____) _____________Cell No.(____)_____________ Cell Carrier _______________________
Would you prefer a text or email reminder? Text Email Both
Date of birth ____________________**Age** __________ **Social Security No.**____________________
Married______ **Single**________ **Widow(er)**_______ **Divorced**______ **No. of children**_______
Height____ **ft.**_____ **in. Weight**___________ **lbs. Pregnant: yes or no**
Occupation: ____________________________________**Employer:**_____________________________________
Employer Address:____ **Phone No.(____)**___________
Name of wife, husband or guardian ____

How did you hear about us?____

Chiropractors you have seen before:
Name__________________________________**City**___________________**State**_____**When seen:**_________
Name__________________________________**City**___________________**State**_____**When seen:**_________

List Medical doctors seen within the past year:
Name__________________________________**City**___________________**State**_____**When seen:**_________
Name__________________________________**City**___________________**State**_____**When seen:**_________
Date of last physical examination:_________________

List all surgeries:
Type____**When**_____________________________________
Type____**When**_____________________________________
Type____**When**_____________________________________

Past accidents or injuries:
Type______________________________**When**_____________________ **Hospitalized? Yes**___ **No**___
Type______________________________**When**_____________________ **Hospitalized? Yes**___ **No**___
Type______________________________**When**_____________________ **Hospitalized? Yes**___ **No**___

List medications and/or vitamins & minerals you are taking:
Type____________________________**For**______________________________**How long** ________________
Type____________________________**For**______________________________**How long** ________________
Type____________________________**For**______________________________**How long** ________________
Use back of page for additional space needed.

Present Complaints: Please check all answers and fill in the blanks where appropriate. The information you provide assists your doctor in obtaining an early understanding of your condition. In the spaces below, please describe the present, major complaint which brought you to this clinic for care. For additional complaints ask the receptionist for extra forms.

Reason for visit:____

____

____

When did this problem begin? ____

Have you had this problem before? Yes or No If yes when? ______________________________________

Is this a work related injury? Yes or No Is this a Motor Vehicle Accident? Yes or No

If your problem began following a specific incident, please explain: ______________________________

____

____

Were you previously treated for this condition? Yes or No

If yes by; Chiropractor MD Therapist Other_________________________________

Please describe the character for your current pain: (you may check more than one answer)

Sharp Stabbing Aches Dull Soreness Weakness Numbness Throbbing

Gnawing Shooting Gripping Constricting

How often are the complaints present? Constant __Hours per day ___Days per week ___Days per month

Since your problem began, is the pain: Increasing Decreasing Not changing

If your current complaints are associated with an old injury and were aggravated (made worse) by a recent incident, please describe the incident and when it occurred:

Date ______________________________ Description ____

____

Indicate how your symptoms are affected by physical activity: (circle one)

_____Symptoms are unaffected by rest, exercise, etc.

_____Symptoms are made worse by exercise or physical activity

_____Symptoms are made worse by rest or inactivity

Are your complaints affecting your ability to work or otherwise be active?

_____No effect

_____Some physical restrictions (able to perform light duty work and household tasks)

_____Need limited assistance with common everyday tasks

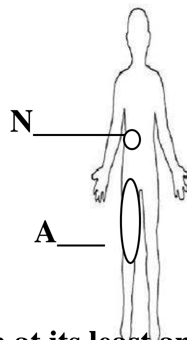
_____Need assistance often

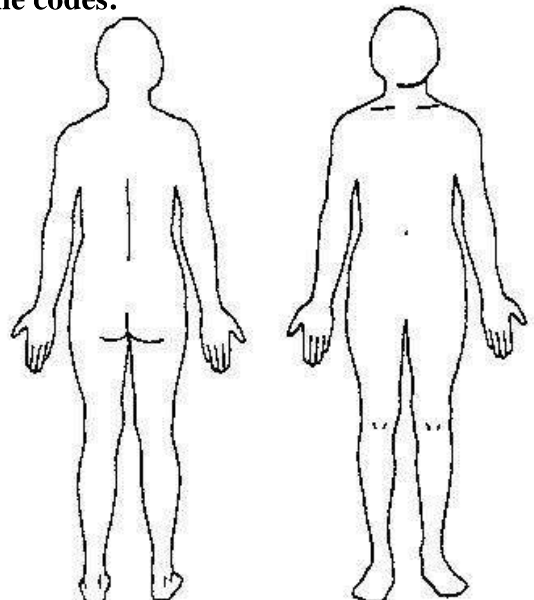
_____Have a significant inability to function without assistance.

_____Am totally disabled (impaired). Cannot care for self

Mark on the picture where you have had symptoms according to the codes:

S=stiffness
A=Aching
P=Pain
N=numbness
T=tingling
B= burning





Rate the severity of your pain at its least and greatest Times by circling two numbers below.

0 1 2 3 4 5 6 7 8 9 10

No Pain ... Excruciating pain

Past and Present Conditions

Below are listed common symptoms, which may suggest the presence of an ailment, involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	Musculoskeletal	Present
[ ]	Neck Pain	[ ]
[ ]	Shoulder Pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand Pain	[ ]
[ ]	Upper back Pain	[ ]
[ ]	Low back Pain	[ ]
[ ]	Leg Pain	[ ]
[ ]	Knee Pain	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw Pain	[ ]
[ ]	Swelling in joints	[ ]
[ ]	Stiffness of joints (list joints)	[ ]

Past	Nervous System	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bedwetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear Pain	[ ]
[ ]	Impaired Vision	[ ]
[ ]	Eye Pain	[ ]
[ ]	Paralysis	[ ]

Past	Cardiovascular	Present
[ ]	Rapid heartbeat	[ ]
[ ]	Chest pain	[ ]

Past	Condition	Present
[ ]	Hemorrhoids	[ ]
[ ]	Rheumatic heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic Pain	[ ]
[ ]	Chronic Cough	[ ]
[ ]	Sinusitis	[ ]

Past	Gynecologic	Present
[ ]	Cramps	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	menopausal symptoms	[ ]

Past	Genito-Urinary	Present
[ ]	Painful urination	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	GI Tract	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	Skin	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Past	Endocrine	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Condition	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]	Bladder infection	[ ]
[ ]	Allergies	[ ]
[ ]	HIV positive/AIDS	[ ]

Please check any of the following that apply to you.

[ ] Tobacco [ ] Alcohol [ ] Water___________

[ ] Tranquilizers/Sedatives [ ] Laxatives

[ ] Regular soda, cans/day____________

[ ] Diet soda, cans/day_______________

YOUR TREATMENT BY US

I consent to the customary examinations, tests and procedures performed at or by the Gonstead Clinic of Chiropractic (clinic) and routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no

guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur.

Your Privacy

We are very concerned with protecting your privacy. We have, and always will, respect the privacy of your medical information. Our Privacy Practices Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your medical information, and of other important matters about your medical information.

- The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.
  The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPPA Compliance Manual, State Law and Federal Law.
- I consent to the use and disclosure of my medical records to carry out treatment, payment activities, and health care operations as set forth in the Privacy Practices Notice. I agree that you may contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me by phone, and may leave messages on my answering machine or with the individuals which answer the phone.
- I consent to your disclosure of my medical records to the following persons, including those involved in my care or payment for that care.
  (circle those that apply) * My spouse *any member of my immediate family *Other_________________________

This consent is effective until revoked by you. You may revoke this consent at any time by fiving written notice of revocation to us. Revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

WE WILL FILE YOUR INSURANCE FOR YOU.

We will prepare any necessary reports and forms to assist you in making collection from the insurance company. Any amount paid directly to the Gonstead Clinic of Chiropractic will be credited to your account upon receipt by us. (Insurance will not be filed if a cash discount is applied).

- I hereby assign the benefits payable for chiropractic services to the Gonstead Clinic of Chiropractic and authorize the clinic to submit a claim to third party payers for payment on my behalf.
- I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

OUR PAYMENT POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. All services rendered by the Clinic are charged directly to you, the client. You are personally and fully responsible for all payments, regardless of whether or not we accept insurance assignment.

- I agree to keep the balance I owe the Clinic at no more than $150, unless we agree in writing to a higher balance. If I do not have insurance, I agree to pay full amounts owed at the time of service is rendered or at the end of each week. If I am an insurance assignment patient, I agree to pay my deductible in full and pay my co-insurance and co-pay at the time services are rendered.
- I understand it is my responsibility to understand my insurance benefits and to inform the clinic of any insurance changes.
- I agree to be responsible for legal fees, collection fees, and any other expenses incurred in collecting fees for my services. **Returned checks will have a $30 fee and balances over 30 days may be subject to interest charges of 1.5% per month.**

We are committed to great service…and expect to be fairly paid for it. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the about information and guarantee this form is completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____________________________________ _________________ ____

Signature of Patient/Personal Representative Date Print Name of Patient/Personal Representative Relationship

Treatment of Minor. I as legal guardian of patient do authorize appropriate chiropractic treatment.

_______________________________________ ________________________ __________________________________

Signature of Guardian Date Print Name Relationship