Van Drisse Chiropractic Center
Patient Information Form

NAME (Last, First, MI) _____

HOME ADDRESS _____
(City) (State) (Zip)

BILLING ADDRESS _____
(City) (State) (Zip)

HOME PHONE_____CELL PHONE_____EMAIL _____

SS#_____-_____-_____ MARITAL STATUS: S / M / D/ W SEX: M / F DATE OF BIRTH____/____/____

NAME OF SPOUSE _____ DATE OF BIRTH ____/____/____

PATIENT'S EMPLOYER_____PHONE:_____

*EMERGENCY CONTACT_____ PHONE: _____

*RELATIONSHIP TO PATIENT _____

How did you hear about our Clinic? _____

ACCIDENT INFORMATION

Is this due to an accident? _____ YES _____ NO DATE _____
Type of accident ____ Auto _____ Work _____ Home _____Other
To who have you made a report of your accident?
_____ Auto Insurance _____ Employer _____ Work Comp _____ Other
Attorney Name (if applicable) _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company (s)assign directly to
Van Drisse Chiropractic Center L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient (For Guardian, or Personal Representative)

Van Drisse Chiropractic Center
502 George Street
De Pere, WI 54115
920.337.0103

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

Van Drisse Chiropractic Center
Health History Form

Name: _____

HABITS:

Do you smoke or chew tobacco? ☐ Yes ☐ No

How much coffee/tea do you typically consume a day? ☐ none ☐ 1 to 2 cups ☐ 3 to 7 cups ☐ 8 or more cups

How much soda/pop do you typically consume a day? ☐ none ☐ 1 to 2 cups ☐ 3 to 7 cups ☐ 8 or more cups

How much alcohol do you typically consume a week? ☐ none ☐ 1 to 2 drinks ☐ 3 to 7 drinks ☐ 8 or more drinks

Typical physical activity at work? ☐ mostly sitting ☐ light manual labor ☐ manual labor ☐ heavy manual labor

General physical activity when not working? ☐ mostly sitting/relaxing ☐ usually active ☐ usually very active

Outside of work, do you exercise on a regular basis? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

How is your father's health? ☐ good ☐ fair ☐ poor ☐ deceased

How is your mother's health? ☐ good ☐ fair ☐ poor ☐ deceased

How is your siblings" health ☐ good ☐ fair ☐ poor ☐ deceased

List any health problems that run in your family. _____

Has anyone in your immediate family ever had a stroke? ☐ Yes ☐ No

FEMALE'S ONLY

Date of last OB/GYN exam: _____

Were the results of your last OB/GYN exam/pap smear normal? ☐ Yes ☐ No ☐ Unsure

Age of each of your children: _____, _____, _____, _____, _____, _____

Underline each symptom/problem you have had in the last year:

painful periods	excessive flow during period	PMS	yeast infection
hot flashes	cramps or backache during cycle	vaginal discharge	miscarriage

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Is there a chance that you might be pregnant? ☐ Yes ☐ No

When did your last menstrual period begin? _____

Do you have irregular cycles? ☐ Yes ☐ No ☐ Unsure

Are you taking oral contraceptives? ☐ Yes ☐ No ☐ Unsure

Do you have an IUD? ☐ Yes ☐ No ☐ Unsure

PREGNANCY WARNING AND CONSENT TO X-RAY

Signature only needed if female

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that if there is a chance that I might be pregnant the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination.

With full understanding of the above, and believing that I am not currently at risk, I give the doctors of Van Drisse Chiropractic permission to perform an x-ray examination on me if they feel it is necessary.

Patient's Signature _____ Date _____

Van Drisse Chiropractic Center
Health History Form

Name: _____

Primary Care Physician (PCP): _____

Date of last appointment with PCP: _____

Have you ever had surgery?	☐ Yes	☐ No
Have you ever been diagnosed with a long-term or ongoing health problem?	☐ Yes	☐ No
Have you ever been diagnosed with cancer?	☐ Yes	☐ No
Have you been sick at all in the last 60 days?	☐ Yes	☐ No
Have you ever had a convulsion, seizure or stroke of any kind?	☐ Yes	☐ No
Have you ever passed out, blacked out or fainted?	☐ Yes	☐ No
Have you been dizzy or lightheaded in the last 60 days?	☐ Yes	☐ No
Do you have any unusual vision or hearing problems recently?	☐ Yes	☐ No
Have you had ringing in your ears in the last 60 days?	☐ Yes	☐ No
Have you had a headache in the last 60 days?	☐ Yes	☐ No
Have you ever had a heart attack or been diagnosed with a heart condition?	☐ Yes	☐ No
Have you ever been diagnosed with high or low blood pressure?	☐ Yes	☐ No
Do you have frequent colds, sinus infections, ear infections or sore throats?	☐ Yes	☐ No
Do you have asthma or any allergies?	☐ Yes	☐ No
Males, have you ever been diagnosed with a prostate problem?	☐ Yes	☐ No
Do you have trouble controlling urination?	☐ Yes	☐ No
Have you had frequent or painful urination in the last 60 days?	☐ Yes	☐ No
Have you had a kidney or bladder infection in the last 60 days?	☐ Yes	☐ No
Do you have a problem with re-occurring kidney/bladder infections?	☐ Yes	☐ No
Have you been constipated or had diarrhea in the last 60 days?	☐ Yes	☐ No
Do you have any sores or skin lesions that aren't healing?	☐ Yes	☐ No
Have you had weakness, twitching or tremors in your arms/hands or legs/feet in the last 60 days?	☐ Yes	☐ No
Have you ever broken a bone or dislocated a joint?	☐ Yes	☐ No
Have you ever had a motor vehicle accident or fender bender?	☐ Yes	☐ No
Have you ever had a fall or injury that required professional attention?	☐ Yes	☐ No
Have you ever been given a permanent disability rating?	☐ Yes	☐ No
Have you ever had a spinal x-ray, MRI, or CAT scan?	☐ Yes	☐ No
Have you ever had chiropractic care before?	☐ Yes	☐ No

Notes: _____

Van Drisse Chiropractic Center
Health History Form

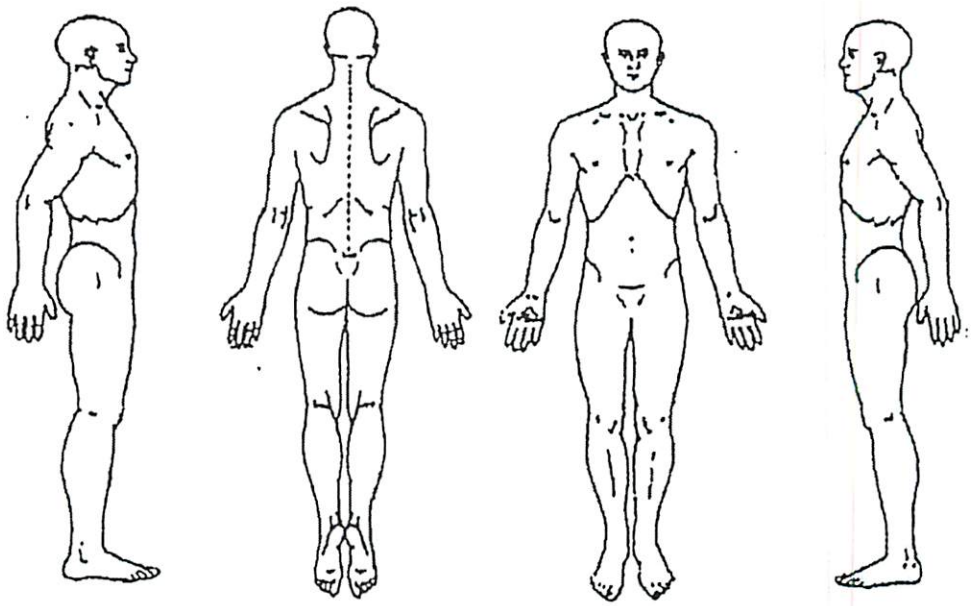
Name: _____

Describe the health problems that you are here for. Be as specific as possible. _____

_____

MARK ON THE PICTURE WHERE YOU HAVE SYMPTOMS. PLEASE USE THE FOLLOWING SYMBOLS:

Stiffness
S S S S S S S S S
S S S S S S S S S
Dull/Aching
O O O O O O O O O
O O O O O O O O O
Stabbing Pain
/ / / / / / / / / /
/ / / / / / / / / /
Burning
x x x x x x x x x x
x x x x x x x x x x
Numbness
- - - - - - - - - - -
- - - - - - - - - - -
Pins & Needles
+ + + + + + + + +
+ + + + + + + + +



On a scale of 0-10, with 0 meaning NO symptoms/can function normally, and 10 meaning very severe symptoms/cannot function at all, where would you rate yourself overall. (Place an "X" on the line.)

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

NO SYMPTOMS VERY SEVERE SYMPTOMS

Have you ever seen a medical doctor, doctor of chiropractic, or physical therapist for this problem? ☐Yes ☐No

Do you have ANY other health problems or symptoms that have not yet been covered today? ☐Yes ☐No

What? _____

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient's Signature _____ Date _____

NOTES: _____

_____

_____

_____

_____

CC: chief complaint O: onset S: severity F: freq. R: radiation Pr: proactive Pa: palliative Hx: prior history/intervention G: tx goals/ADL

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Authorized Provider Representative
Personal Representative's Name Printed	Personal Representative's Authority

I am acknowledging that I have received a copy of the PRIVACY POLICY and this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Personal Representative's Authority

CONSENT FOR TELEPHONE AND EMAIL APPOINTMENT REMINDERS AND TREATMENT ALTERNATIVES

Your chiropractor and members of the practice staff may need to use your name, address, phone number, email address, and your clinical records to contact you with appointment reminders, and information about treatment alternatives. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are consenting for us to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you choose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give us this consent or revoke it in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders or information about treatment alternatives at any time.

This consent is effective as of _____. Unless you otherwise revoke it, this consent will expire one year after the date on which you last received treatment or services from us.

I CONSENT to my phone number and/or email address being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Authorized Provider Representative
Personal Representative's Name Printed	Personal Representative's Authority

Preferred Telephone Number for This Purpose: _____ ☐ Home ☐ Cell ☐ Work

Preferred Email Address for This Purpose: _____ ☐ Personal ☐ Work

I am acknowledging that I have received a copy of this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my name, address, phone number, email address, and my clinical records to contact me with appointment reminders, and information about treatment alternatives.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Personal Representative's Authority

Website Membership Enrollment

The Information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	