WEISS CHIROPRACTIC WELLNESS CENTER

Dr. David Weiss -- Dr. Michael Weiss -- Dr. Samantha Murphy -- Dr. Rebecca Miller
124 W. Savidge St. Spring Lake, MI 49456 Phone: 616.846.2330 Fax: 616.846.3283

Name:____ Gender: ___________ Date:______________
Address: ______________________________ City/State: ____________________________ Zip: _________
Cell Phone: ____________________________ Home Number: _____________________________________
Email: ______________________________________Date of Birth: ____________________ Age: ________
Employer: ___________________________________ Occupation:_________________________________
Spouse's Name: _______________________________ Spouse's Date of Birth:________________________
Primary Medical Doctor: ____
Address____**Phone Number**_______________________

PRIMARY REASON FOR CONSULTING OUR OFFICE

Please list complaints in order of priority.

1. **Primary complaint**____

Reason for today's visit: ❒ Emergency ❒ New Injury ❒ Old injury ❒ Chronic Pain ❒ No complaints /Wellness
Pain or problem started on____________________________ Onset of problem was: ❒ Gradual ❒ Sudden
Is this due to: ❒ Auto ❒ Work ❒ Sports/play ❒ Routine/Household activity ❒ Other Explain __________
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
Have you ever had the same or similar condition? ❒ Yes ❒ No Explain ________________________________

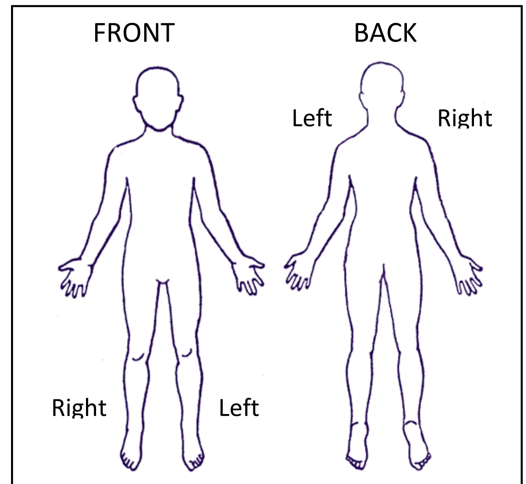
On a scale of 0 to 10, how would you rate your pain/symptoms today? (Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

Is this condition worse at certain times of the day? ❒ Morning ❒ Afternoon ❒ Evening ❒ During sleep
This condition is getting: ❒ Better ❒ Worse ❒ Staying the same - This condition is: ❒ Constant ❒ Comes and goes
What makes the problem worse? ❒ Standing ❒ Sitting ❒ Lying ❒ Bending ❒ Lifting ❒ Twisting
❒ Other ____

Is there anything you can do to relieve the problem?
❒ Yes, describe:____
❒ No, what have you tried to do that has not helped?____________
____

Describe the pain: ❒ Sharp ❒ Dull ❒ Numbness ❒ Tingling
❒ Aching ❒ Burning ❒ Stabbing ❒ Other____________________



RATE YOUR PAIN

Place an "X" on the drawings wherever you have pain.
Beside the "X" indicate the type of pain you are experiencing:

A = Ache **B = Burning**
ST = Stabbing **SP = Spasm**
N = Numbness **P = Pins and Needles**
T = Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

2. **Secondary complaint** ____

Pain or problem started on____________________________ Onset of problem was: ❒ Gradual ❒ Sudden
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
On a scale of 0 to 10, how would you rate your pain/symptoms today? (Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

3. **Tertiary complaint** ____

Pain or problem started on____________________________ Onset of problem was: ❒ Gradual ❒ Sudden
Frequency of problem: ❒ 10% ❒ 20% ❒ 30% ❒ 40% ❒ 50% ❒ 60% ❒ 70% ❒ 80% ❒ 90% ❒ 100%
On a scale of 0 to 10, how would you rate your pain/symptoms today? (Identify by putting a O around the level of pain today, a ☐ around the level of pain at its best, and a Δ at its worst)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

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Activities of Daily Living: Mark with an "X" in the corresponding column.
If activity is affected, please label how long you are able to perform the activity before having to stop.

	Mild (Can perform but causes pain)	Moderate (Limited ability to perform)	Severe (Cannot perform)	How long are you able to perform activity?
Sitting				
Standing				
Walking				
Running				
Lying down				
Lifting				
Typing				
Driving				
Working				
Exercising				
Vacuuming				
Cooking				
Cleaning				
Dressing				
Sleeping				
___________				

Have you been under medical care recently or for this problem? ❐ Yes ❐ No
When did you last see a chiropractor? _______________ Dr/Office name:___________________________________
Why did you see this chiropractor?______________________________________Were you helped? ❐ Yes ❐ No
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?
____
Did you follow it? ❐ Yes ❐ No If not, why ____
If you are changing chiropractors, why are you changing?____

REVIEW OF SYSTEMS

Mark with an "X" all that apply.

Constitutional	❐None ❐chills	❐daytime drowsiness ❐fatigue	❐fever ❐loss of appetite	❐night sweats ❐weight gain / loss (circle)
Eyes/Vision	❐None ❐blindness ❐blind spots	❐cataracts ❐double vision ❐eye problems	❐itching ❐photophobia ❐tearing	❐wears contacts/glasses
Ears, Nose & Throat	❐None ❐dizziness ❐ear discharge ❐ear pain	❐fainting ❐frequent sore throats ❐headaches ❐hearing loss	❐history of head injury ❐loss of sense of smell ❐nosebleeds ❐nasal congestion	❐runny nose ❐sinus infection ❐ringing in ears ❐allergies
Respiration	❐None ❐asthma	❐cough ❐coughing up blood	❐shortness of breath ❐sputum production	❐wheezing
Cardiovascular	❐None ❐claudication (leg pain and ache) ❐heart problem	❐high blood pressure ❐low blood pressure ❐orthopnea (difficulty breathing lying down)	❐heart murmur ❐palpitations ❐shortness of breath with exertion	❐varicose veins ❐cold hands/feet ❐chest pain ❐fainting
Gastrointestinal	❐None ❐abdominal pain ❐abnormal stool (Color/consistency)	❐belching ❐black tarry stool ❐constipation ❐diarrhea	❐difficulty swallowing ❐heartburn ❐hemorrhoids ❐indigestion	❐jaundice ❐ulcers ❐rectal bleeding ❐loss of bowel control

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Female	❒None/NA ❒abnormal vaginal bleeding I… I… My menses…	❒birth control ❒breast lump/pain ❒burning urination ❒am currently pregnant ❒currently have menses ❒are regular	❒frequent urination ❒hormone therapy ❒irregular menstruation ❒am NOT currently pregnant ❒currently DO NOT have menses ❒are NOT regular	❒vaginal discharge ❒cramps ❒urine retention/ incontinence
Male	❒None/NA ❒erectile dysfunction	❒burning urination ❒hesitancy/dribbling	❒frequent urination ❒urine retention/incontinence	❒prostate problems
Skin	❒None ❒change in nail texture	❒change in skin color ❒hair loss ❒hives	❒history of skin disorders ❒itching ❒numbness	❒rash ❒skin lesions/ulcers ❒varicosities
Nervous System	❒None ❒dizziness ❒facial weakness ❒headache	❒limb weakness ❒loss of consciousness ❒loss of memory ❒numbness	❒seizures ❒sleep disturbance ❒slurred speech ❒stress	❒stroke ❒unsteadiness of gait/loss of balance
Psychological	❒None ❒anxiety ❒behavioral change	❒bi-polar disorder ❒confusion ❒convulsions	❒depression ❒insomnia ❒loss or change of appetite	❒memory loss ❒mood change ❒tension/stress
Hematologic	❒None ❒anemia	❒bleeding ❒blood clotting	❒blood transfusion ❒bruising easily	❒fatigue ❒lymph node swelling

HEALTH HISTORY

Now Have / In the Past / Family History

❍ ❒ △ Fractured/broken bones
❍ ❒ △ Auto accidents
_______ 0-5 years
_______ over 5 years
❍ ❒ △ Other accident or falls
❍ ❒ △ Back curvature
❍ ❒ △ Arthritis
❍ ❒ △ Diabetes
❍ ❒ △ Cancer
❍ ❒ △ Learning disability
❍ ❒ △ Eating disorder

❍ ❒ △ Trouble Sleeping
_______ Stomach sleeper
_______ Side sleeper
_______ Back sleeper
❍ ❒ △ Numbness / tingling
_______ Hand / Fingers
_______ Arms
_______ Legs
_______ Feet / Toes
_______ Buttocks
_______ Head or face

❍ ❒ △ Muscle Spasms
❍ ❒ △ Neck pain/stiffness
❍ ❒ △ Shoulder pain / Arm pain
❍ ❒ △ Upper back pain/stiffness
❍ ❒ △ Mid back pain/stiffness
❍ ❒ △ Low back pain/stiffness
❍ ❒ △ Hip pain
❍ ❒ △ Swollen/painful joints
❍ ❒ △ Hepatitis
❍ ❒ △ Pacemaker
❍ ❒ △ Drug /Alcohol addiction

Have you ever had surgery? ❒ Yes ❒ No Explain____
Do you have allergies of any kind? ❒ Yes ❒ No Explain ____

SOCIAL HISTORY & LIFE CHOICES

Exercise: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Alcohol: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Drugs: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Tobacco: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Caffeine Products: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never
Diet: ❒ Poor ❒ Fair ❒ Good ❒ Excellent
Mental Stress: ❒ Mild ❒ Moderate ❒ Marked

How do you want us to handle your problems? ❒ Maximum Correction (Correct the cause of the problem so it does not return)
❒ Temporary Relief (Help the symptom but do not fix the cause of the problem)
Why did you come to our clinic, and what are your expectations of us?_________________________________
____
Are your problems affecting your ability to either perform or enjoy work, activities or hobbies? ❒ Yes ❒ No
If your problems go uncorrected and get worse, do you think you will be able to perform or enjoy these activities?
❒ Yes ❒ No

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ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

Full Name: ____

Preferred method of communication for patient reminders (Check one): ❒ Email ❒ Phone ❒ Mail

DOB: ______________ **Gender**:___________ **Preferred Language:** ❒ English ❒ Other:_________________

Smoking Status (Check one): ❒ Every Day Smoker ❒ Occasional Smoker ❒ Former Smoker ❒ Never Smoked

CMS requires providers to report both race and ethnicity

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

Ethnicity (Check one): ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications) ❒ **None**

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ❒ **None**

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:_____ /_____ Pulse ______

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INFORMED CONSENT

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

________________________________ ________________________________ ____________
Print Name ***Signature*** ***Date***

****

Consent to evaluate and adjust a minor child:

I, _________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

________________________________ ________________________________ ____________
Print Name ***Signature*** ***Date***

PAYMENT POLICY AND FEE SCHEDULE

In our best efforts for clear communication at Weiss Chiropractic Wellness Center, please read the **cash-fee** structure and sign below to acknowledge. Weiss Chiropractic Wellness Center accepts the following forms of payment:

1. **CASH / CHECK / CREDIT & DEBIT CARDS** - Every time you come in.
   After 60 days of non-payment, a $25.00 late fee will be added to your account to be compounded monthly.
   Checks will also be subjected to a $25.00 administrative fee.
2. **INSURANCE ASSIGNMENT**- Co-pay, insurance reimbursement signed over to our clinic.

Services	Cash Fee	Services	Cash Fee
Consultation	No charge	X-Rays	$50- $150
Exams	$40 - $80		
Adjustment	$40 - $48	Massage – one hour	$70
Mechanical Traction	$25	Massage – ½ hour	$40

Mechanical traction is a type of Physical Therapy and is NOT part of a chiropractic adjustment. Additional charges may apply for this service.

____ ________________________________
Patient Signature ***Date***

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HIPPA PRIVACY PRACTICES

I acknowledge that Weiss Chiropractic Wellness Center "Notice of Privacy Practices" has been made available to me. I understand I have the right to Weiss Chiropractic Wellness Center's Notice of Private Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Weiss Chiropractic Wellness Center.

The Notice of Privacy Practice is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Weiss Chiropractic Wellness Center's duties with respect to my protected health information.

Weiss Chiropractic Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

____ ____________________________
Signature of Patient or Personal Representative ***Date***

____
Description of Personal Representative's Authority (Parent, legal guardian, etc.)

Please list below the names of person(s) authorized to gain access to patient account information:

____
____
____

PRIVACY & COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

❒ Text - Cell phone number____

Email communication:

❒ I give my permission to send occasional emails with birthday gifts, news, specials, and events.
(We will not sell or give your address to third parties)

By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office.

____ ____________________________
Signature of Patient or Personal Representative ***Date***

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CLINIC POLICIES

We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.

1. Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made. For your convenience, Weiss Chiropractic Wellness Center accepts cash, checks, Visa, MasterCard, and Discover.
2. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection fees, interest charges and other expenses incurred in collecting your account. We utilize Allied Business Services and the Ottawa County small claims court to collect past due accounts.
3. In the event that a check is written to this office and it is returned from our bank due to insufficient funds or the account is closed, I agree to pay for the fees of the dishonored check according to the amount allowed under Michigan law. Currently the fee is $25.
4. An insurance contract is **between the patient and the patient's insurance company**; therefore it is the responsibility of the patient to keep their account current.
5. Patients involved in litigation (law suits) are, as others, responsible for payment of their services at our clinic.
6. All fees for services rendered will be immediately due for patients suspending or terminating care.
7. Any amount paid to the Company for x-rays is for evaluation purposes only, and images remain the permanent property of Weiss Chiropractic Wellness Center.
8. 24 hours notice is required when cancelling or rescheduling appointments. Weiss Chiropractic Wellness Center reserves the right to charge up to the full amount owed for scheduled services in the event of a cancellation without 24 hours notice, including no-show appointments. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

By signing below, I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

My signature also authorizes the payment be made directly to Weiss Chiropractic Wellness Center for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

I understand and agree that Weiss Chiropractic Wellness Center has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of Weiss Chiropractic Wellness Center to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand that the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ __________________________

Signature of Patient ***Date***

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APPOINTMENT POLICY

This policy is designed to bring clarity to all our patients about the expectations you may place on this office, and the expectations this office will place on you, in regards to **making & keeping appointments**.

What you can expect from our office:
As a member of your healthcare team we strive to always run on time for your regularly scheduled adjustments & massage appointments. The unpredictable natures of life will, from time to time, cause changes that none of us can expect. This is what you can expect from our office and we ask you to politely help hold us accountable to our goal for patient care.

What we expect from you:
As a patient of this practice it is expected that you will follow through with your scheduled chiropractic adjustments & massages. We understand that your life happens outside of this office and that there will be occasions that make it impossible for you to be here for some of those visits at your scheduled time. We ask that you simply call the office to reschedule that appointment within the same day whenever possible. **Note:** (massage patients must give 24 hours notice of cancellation or you will be charged a $25 appointment cancellation fee). This helps the office to utilize our time most efficiently to serve your needs and the needs of all our patients. As an added service we have automatic text and email reminders available to help you keep track of your appointments so please sign up to use whichever one would work best for you.
When no call is made to this office to reschedule your appointment it not only creates an issue with our schedule, and the schedule of ***other patients*** to be seen that day, but it also requires us to contact you at times that may not be most convenient for you to get your appointment rescheduled.

I understand and will follow Weiss Chiropractic's appointment policy to the best of my ability

______________________________ ______________________________
Signature of Patient ***Date***