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New Patient Intake - Chiropractic

Name _____ **Today's date:** ____/____/_____

Address_____**City**_____**State**_____**Zip**_____

Birthdate ____/____/_____ **Age** _____ **Sex** _____ **E-mail** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Other_____

Name *(if applicable)* _____

Do you have children? ☐ Yes ☐ No **Ages:** _____

Would you like to be added to our email list? We do not share your information and typically use it so you know about upcoming classes or lectures at Genesis!
☐ YES ☐ NO

PHONE NUMBERS

Home	**Cell**	**Work**

Primary Care Physician _____**Phone**_____

Employer _____**Occupation** _____

EMERGENCY CONTACT INFORMATION

Contact is: ☐ Parent ☐ Guardian ☐ Spouse ☐ Domestic Partner ☐ Other_____

Name _____ **Phone Number** _____

How did you hear about us?

_____

_____

_____

(over)

Patient History

Please list your chief complaint(s) in order of their importance to you:
(Please list the intensity of the pain on a scale of 1-10, with 10 being the most severe)

1. _____
2. _____
3. _____
4. _____

Have you had previous chiropractic care? With whom? When (approximately)?

_____

Please list other healing arts providers caring for you currently:

1. _____
2. _____
3. _____

Past Medical History: (Major illnesses, surgeries or injuries) Date

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Current Prescription Medications:

	Drug Name:	Dosage:	Taking since:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement Name:	Dosage:	Taking since:
1.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____

Please list any allergies: (medications, inhalants, foods, others)

1. _____
2. _____
3. _____

Are you a cigarette smoker? Yes _____No _____ Quit (when)?_____

What is your current occupation?

_____

Who in your family has had: Diabetes _____ Heart disease/stroke _____

Cancer _____ Arthritis _____Other_____

Do you exercise? _____ If yes, please list the types of exercise and the frequency.

1. _____
2. _____
3. _____

List the foods you typically consume for breakfast, lunch and dinner.

Breakfast	Lunch	Dinner

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)? _____

Do you drink soda? _____ **If yes, how many times each week?** _____

Do you drink fruit juice? _____ **If yes, how many times each week?** _____

Do you drink coffee? _____ **If yes, how many cups each day?** _____

Do you drink alcohol? _____ **If yes, how many drinks each week?** _____

(_____ Beer _____ Wine _____ Hard)

(over)

Review of Systems

Please circle any of the conditions or symptoms below, if you have experienced them significantly within the last 6 months.

General
Fatigue Weight change Fever / chills
Weakness Night sweats Insomnia

Skin
Itching Rashes Hair/Nail changes

Head
Headache Trauma Dizziness

Nose
Bleeding Discharge Sinus infections Allergies
Post nasal drip

Eyes
Double vision Blurring Pain Discharge
Poor vision

Mouth/Throat
Sores Gums bleeding Hoarseness
Taste Silver Fillings Pain swallowing

Lungs/Breathing
Wheezing Cough Pain
Shortness of breath Coughing blood

Breasts
Masses Pain Discharge

Cardiovascular
Rapid heart beat Swollen ankles Pain
Angina High-blood pressure Calf pain

Muscles, Joints & Bones
Trauma Pain Arthritis

Gastrointestinal
Appetite Nausea/Vomiting Indigestion
Constipation Diarrhea Hemorrhoids
Blood in stool Gas/belching Pain

Urinary/Urination
Pain Waking at night Incontinence
Frequent Urgency Blood

Sexually Transmitted Diseases
Syphilis Gonorrhea Chlamydia
Herpes Sores / discharge Pelvic pain

Female-Menses
Heavy bleeding Pain Irregular cycle
Menopause Spotting PMS

Male
Testicular pain Swelling Masses Discharge

Endocrine
Thyroid conditions Hormone medications
Heat / Cold intolerance Diabetes

Blood-Lymphatic system
Anemia Bleeding tendencies
Swollen lymph nodes Transfusions

Neurologic
Fainting Seizures In-coordination
Numbness/tingling Speech problems
Paralysis/Weakness Tremor

Psycho-social
Anxiety Depression Drug/alcohol abuse
Phobia Memory loss

Thank you for taking the time to fill out this form, as the information you have provided will significantly help the Doctor to help you. Please use this page to include anything you feel may help the Doctor to understand your situation better. You may also use it to complete any items that needed additional space on the previous sheets.

Patient Financial Policy

Thank you for choosing Genesis Natural Medicine Center as your naturopathic health care provider. We are committed to walking with you on your road to good health. It is important to us that you understand your financial responsibility to Genesis to ensure there will not be any misunderstanding regarding payment for services rendered. Please ask us if you have any questions about our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

Our doctors require that all patients complete the New Patient Intake Form prior to seeing the doctor. This information needs to be updated annually or at the time of an appointment if there are information changes (i.e. address, name, email, insurance information, etc.).

PAYMENT: We require full payment at the time of service. We accept cash, Visa, MasterCard and Discover. Our policy is to take credit card information before a phone consult unless other arrangements were made prior to the appointment.

INSURANCE: It is the patient's responsibility to provide Genesis Natural Medicine Center with current, accurate insurance information. Our doctors use your insurance information when working with one of our labs so they can submit the claim for payment. There are some insurance plans that do not cover labs when ordered by a naturopath (i.e. Medicare, AHCCA, Tricare, etc.). When your insurance changes please give the front office your new insurance card.
Genesis understands how expensive health care can be for our patients. We have partnered with Ronnette's Medical Billing and Coding to provide to you an excellent referral service to enable you to file your claim for reimbursement. Ronnette's Medical Billing and Coding charges our patients $10 to file a claim. She accepts cash and checks only. If you choose to use her service, we will collect the payment during checkout and provide you with her information. Ronnette picks up receipts to begin the reimbursement process once a week. She will contact you to discuss the details of her service with you.

MEDICARE: *Only* our Chiropractor accepts Medicare. If you are a Chiropractic patient and a Medicare recipient, please provide us with your current Medicare card. You will be charged the Medicare allowable rate at the time of service. Our Medical Biller and Coder will file your claim for reimbursement. Your reimbursement will be mailed directly to you. If you have any questions, please speak to our front office.

GYNECOLOGY VISITS: If a Pap test has been ordered, the lab bill will either be submitted to your insurance, or billed directly to you.

DISCOUNTS: Genesis Natural Medicine offers discounts to patients. After the first initial appointment, any follow up visits reflect only the time spent with the doctor. We do not charge a flat rate for follow up visits as is the practice of many medical offices. We charge based on 15 minute increments, this gives our patients a considerable savings.
Many patients do not have insurance. We offer lab work at doctor pricing. This is a significant savings for our patients.
At Genesis Natural Medicine Center the more expensive a supplement is, the deeper the discount. It is important to us to offer supplements that are Rx quality at the best possible rate.

CANCELLATION POLICY: Genesis Natural Medicine Center has a 24 hour cancellation / rescheduling policy. The doctor has reserved your appointment time specifically for you. For your convenience, we will call you 48 hours in advanced to remind you of your appointment.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $50.

Thank you for understanding our Financial Policy. We appreciate the opportunity to provide our services for your medical needs. If you have any questions, we encourage you to speak with the front office.

I have read and understand the Genesis Natural Medicine Center Financial Policy.

Print Name **Sign Name** **Date**

Chiropractic Informed Consent

Dear Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

It is not uncommon that patients have some increased discomfort after an adjustment. If this happens, you can apply ice to the area and rest it. If you are concerned about this discomfort or develop any new symptoms you can call this office or if you are out of town, or unable to contact the doctor, you can present yourself to an emergency room.

If any tests requested by Dr. Weiner are performed within or outside this office (laboratory or other diagnostic procedures), the doctor will notify you of the results when they are available.

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. Dr. Weiner will use this procedure to treat you. He may use his hands or a mechanical instrument upon your body in such a way as to move your joints, resulting in the possibility of an audible "pop" or "click". You may feel a sense of movement. Signing this form indicates your request and consent to the performance of chiropractic adjustments and other chiropractic procedures; including various modes of physical therapy and, if necessary, diagnostic x-rays, by the Doctor of Chiropractic named below, and/or anyone working in this clinic authorized by the Doctor of Chiropractic listed below.

Other treatment options for your condition may include self-administered, over the counter analgesics and rest, medical care and prescription drugs such as anti-inflammatories, muscle relaxants, hospitalization, or surgery. If you choose to use one of the above noted "other treatment" options, please be aware that there are risks and benefits associated with such options which you may wish to discuss with your primary medical physician.

You will have the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel, the nature and the purpose of chiropractic adjustments and other procedures. Signing this form signifies your understanding that results are **not guaranteed**.

Furthermore, signing this form indicates your understanding that, as in all health care, in the practice of Chiropractic there are some very slight risks to treatment, including, but not limited to muscle sprains and strains, fractures, disc injuries and strokes. Your signature affirms that you do not expect the doctor to be able to anticipate and explain all risks and complications and that you wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in your best interest.

I have read the above consent and will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Printed Name **Signature (of Patient or Guardian)** **Date**

Doctor's Signature

HIPAA Compliance Form

How We Collect Information About You: Genesis Natural Medicine Center, PLC ("Genesis ") and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, sell, lend, or disseminate any information about applicants or clients who are treated by Genesis as it is considered confidential and is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health or counseling services (including notification of health lectures, seminars, events, etc.) which may require communication between other health care providers, medical product or service providers, pharmacies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need; or to obtain or purchase any type of medical supplies, devices, or medications.

_____

Print Name ***Sign Name*** ***Date***