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***New Patient Form-Child (Under 18)***

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender (circle one): Male Female

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity\* (circle one): Hispanic/Latino Non-Hispanic/Latino I decline to answer

Race\* (circle one): American Indian or Alaska Native / Asian / Black or African American /

White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Does child live with (circle one): Both Parents Father Mother

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the type of care you desire: Temporary relief / Long-term corrective / Dr. Recommendation

Preferred method of communication for patient reminders: Email / Phone / Mail

\*Required per Federal Guidelines



***Complaint Form***

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age: \_\_\_\_\_\_\_\_\_\_

List and date **ANY** surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List and date **ANY** accidents or serious injuries (broken bones or dislocations): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List and date **ANY** diagnosed diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had (circle all that apply): Spinal X-Rays MRI CAT Scan

**CURRENT COMPLAINTS/SYMPTOMS:**

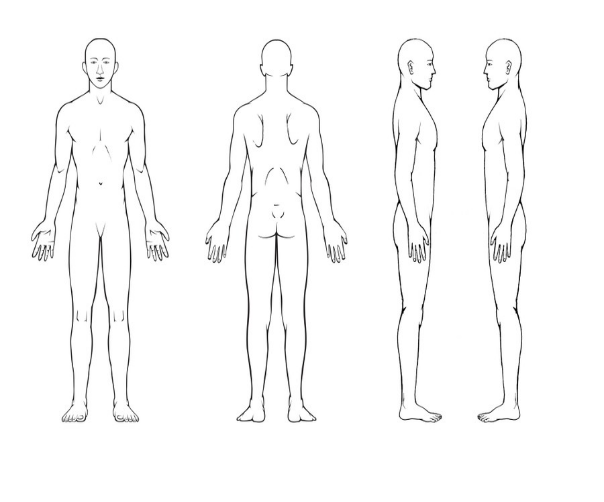
When did you first notice the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the problem (Be as specific as possible): ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Numbness** | **xxxxxxxxx** | **The Problem:** |  |
| **Pins & Needles** | **…………** | **Comes and goes** | **Is Constant** |
| **Burning** | **ooooooooo** |  |  |
| **Aching** | **vvvvvvvvv** | **The problem came on:** |  |
| **Stabbing** | **lllllllllllllll** | **Gradually** | **Suddenly** |

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

**PAIN LEVEL:** On a scale of 1-10, with 0 being

you’re pain free and can function quite well, and 10

being you’re in very severe pain and cannot function

at all, where would you rate yourself? (Place an X on the line.)

|  |
| --- |
|  |
| 0 1 2 3 4 5 6 7 8 9 10 |

**NO PAIN VERY SEVERE PAIN**

What activities, positions, or movements make the problem **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities, positions, or movements make the problem **better**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had this problem before: Yes\_\_\_\_\_ No\_\_\_\_\_ if Yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had chiropractic care before? Yes\_\_\_\_ No\_\_\_\_ If yes, from whom?\_\_\_\_\_\_\_\_\_

For what problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any medications (Include regularly used over the counter medications)**

|  |  |
| --- | --- |
| **Medication Name** | **Dosage and Frequency (ie. 5 mg once a day, etc.)** |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Reaction** | **Onset Date** | **Additional Comments** |
|  |  |  |  |
|  |  |  |  |

**Family Medical History (Record one diagnosis in your family history and the affected)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnosis** | **Father**  **Alive: Y\_\_ N\_\_** | **Mother**  **Alive: Y\_\_ N\_\_** | **Sibling:**  **How many: \_\_\_\_** | **Offspring:**  **How many: \_\_\_\_** |
| Example: heart disease |  |  |  |  |
|  |  |  |  |  |

Indicate Habits: Smoking, \_\_\_\_\_pks/day Alcohol, \_\_\_\_\_\_drinks/day Coffee, \_\_\_\_\_\_cups/day

**CIRCLE ALL THE SYMPTOMS YOU CURRENTLY HAVE AND UNDERLINE ANY YOU HAVE HAD**

**GENERAL SYMPTOMS GASTRO-INTESTINAL CARDIOVASCULAR EYE/EAR/NOSE/THROAT**

Headaches Poor appetite Rapid heart rate Poor Vision

Fevers Excessive hunger Slow heart rate Crossed eyes

Chills Belching or gas High blood pressure Poor hearing

Night sweats Nausea Low blood pressure Earache / Infection

Fainting Vomiting Pain over heart Ringing in ears

Dizziness Pain over stomach Heart trouble Nose bleeds

Convulsions Constipation Swelling of ankles Sore throat / hoarseness

Fatigue Diarrhea Poor Circulation Asthma

Nervousness Hemorrhoids

Loss of Weight

Allergies **SKIN RESPIRATION GENITO-URINARY**

Hernia ItchingChronic Cough Frequent / painful urination

Weakness Bruise easily Spitting blood Blood in urine

Twitching Eczema Chest pain Inability to control urination

Swollen joints Difficulty breathing Prostate trouble

Tremors Male / Female reproduction

Please list **ANY** other health problems or symptoms not covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Informed Consent***

The primary treatment used by doctors of Chiropractic is the spinal adjustment. The doctor of Schwartz Chiropractic and Wellness, Inc. will primarily use that procedure to treat you.

**The nature of the chiropractic adjustment.**

The doctor of Schwartz Chiropractic and Wellness, Inc. will use their hands or mechanical device upon your body in such a way to move your joints. That may cause an audible “pop” or click,” much as you have experienced when you “crack” your knuckles. You may feel or sense movement.

**The material risks inherent in chiropractic adjustment.**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority (Dr. Scott Halderman, DC, MD) saying that there is **at most** a one-in-a-million chance of such an outcome. Since even that risk should be avoided, if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

**Ancillary treatments.**

In addition to chiropractic adjustments, the doctor of Schwartz Chiropractic and Wellness, Inc. may choose to use physiotherapy to aid your body in healing. Physiotherapy may include hot/cold packs, high/low frequency current, diathermy, ultrasound, electric muscle stimulation, interferential, massage, vibration, and/or traction. These treatments, if used, do not involve any additional significant risks.

**The availability, nature, and risk of other possible treatment options.**

Other treatment options for your condition include:

* Self-administered, over-the-counter analgesics and rest
* Medical care with prescription drugs such as anti-inflammatory, muscle relaxants, and painkillers
* Hospitalization with traction
* Surgery

Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, the patient’s pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, the patient’s pain tolerance and self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care bears additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risk inherent in surgery includes adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

**The risks and dangers attendant to remaining untreated.**

Remaining untreated allows the formation of adhesions and reduces the mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date­­ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**761 Milford Street**

**Watertown, WI 53094**

**920-390-4430**

***NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
* Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed a copy of this office’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Schwartz Chiropractic and Wellness, Inc. restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Schwartz Chiropractic and Wellness, Inc. is not required to agree to my requested restrictions, except in the case of where the disclosure is to a health plan for purposes of carrying out payment, and the health care item or service for which you, or a person on your behalf, has paid our practice in full.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if under 18 years old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Financial Agreement**

I authorize my insurance company to pay Schwartz Chiropractic and Wellness, all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions. I authorize Schwartz Chiropractic and Wellness to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

For my convenience, I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Schwartz Chiropractic and Wellness, Inc. All past due accounts are subject to a finance charge of 1.5% per month or max allowed by law. The understanded responsible party promises to pay for services in accordance with the above terms. In the event it becomes necessary for Schwartz Chiropractic and Wellness, Inc. to incur collection costs or institute suit to collect any amount under this agreement, the undersigned promises to be responsible for charges incurred, to pay all additional costs, charges, collection fees and expenses, including reasonable attorneys’ fees and costs, if incurred for the collection or otherwise and submits to jurisdiction and venue in Dodge County, WI. A fee of $45 will be applied to my account for each returned check. All rates are Time of Service Rates and must be paid at the time of service.

**CANCELLATION POLICY**: A 24-hour notice is required for all cancelled appointments. For any missed and or no show/no call appointments, a $45 service fee will be applied to my account.

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**