NEW PATIENT QUESTIONNAIRE

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

1. Patient Name

First Name _____ Last Name _____ Date _____

2. Date of Birth _____ **Height** _____ **Weight** _____

3. Home Address

Street/P.O. Box _____ City _____ State _____ Zip Code _____

4. Contact Information

Mobile Phone/Home Phone _____ Primary Email Address _____

5. Emergency Contact Information

Emergency Contact Name _____ Contact Phone Number _____ Relationship to Patient _____

6. Did anyone refer you to our office?

☐Yes ☐No

If yes, who?

_____

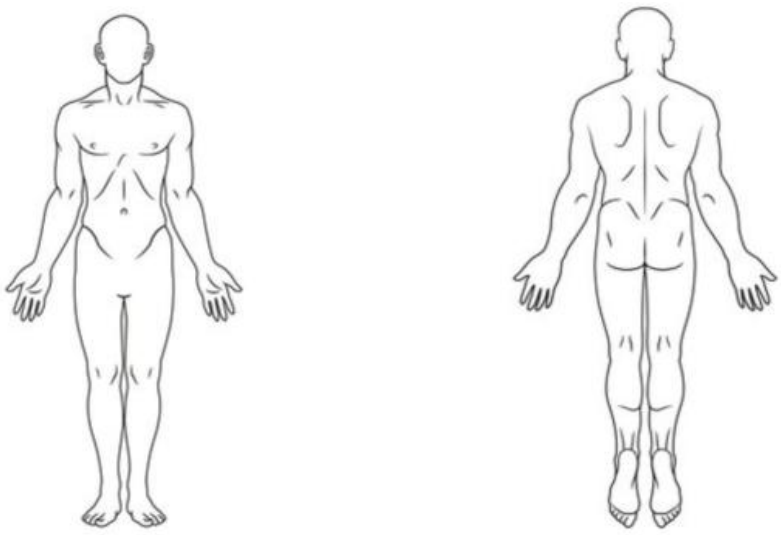
7. Would you like to receive text reminders for appointments?

☐Yes ☐No

HISTORY OF PRESENTING ILLNESS / INJURY

Fill out this section as accurately as possible. Select the area(s) on the models below where you are experiencing pain.

8. Body Map / Drawing



9. When did this condition begin?

Approximate date this condition began (exact date not required).

_____

10. Do you know what caused this condition?

☐Of unknown origin ☐After a fall ☐After a long drive ☐After a poor night's sleep ☐After a slip
☐After lifting an object ☐ After over-arching or reaching ☐After performing yardwork
☐After performing household chores ☐After sitting in one place too long ☐After a long flight
☐Associated with prolonged or chronic illness ☐Other

If other, please specify.

_____

11. Please indicate the frequency of your discomfort.

☐Constant ☐Frequent ☐Intermittent ☐Occasional ☐Random ☐Recurring ☐On and Off

12. What term(s) best describe(s) the level of your discomfort? Choose all that apply.

☐Aching ☐Annoying ☐Burning ☐Deep ☐Dull ☐Heavy ☐Intolerable ☐Pulling ☐Sharp
☐Shooting ☐Stabbing ☐Throbbing ☐Stiffness/Tightness ☐Tingling ☐Other

If other, please specify.

_____

13. Has the complaint gotten better, worse or staying the same?

☐Better ☐Worse ☐Staying the same ☐Had some relief which lasted for awhile

14. On a scale of 0 (no pain) to 10 (intolerable), how would you rate your pain level? Indicate all that are impacting you.

Location	**0-10**
Neck	
Mid Back	
Low Back	
☐Shoulder ☐Arm ☐Wrist ☐Hand	
☐Hip ☐Leg ☐Ankle ☐Foot	
Other Area(s)	

If other, please specify.

_____

15. What improves this condition or gives you relief? Choose all that apply.

☐Nothing ☐Chiropractic Care ☐Prescription Medications ☐Cold Packs ☐Exercise
☐Redirecting Attention ☐Rest ☐Heat Packs ☐Stretching ☐Massage ☐Work
☐Physical Therapy ☐Over-the-Counter Medications ☐Other

If other, specify.

_____

16. What aggravates this condition?

☐Nothing ☐Almost any movement ☐Athletic activity and/or exercise ☐Stress ☐Carrying or lifting
☐Changing positions ☐Coughing and/or sneezing ☐Standing ☐Daily child or pet care
☐Getting out of bed, chair or car ☐Looking over shoulder ☐Household chores (cooking, cleaning, etc.)
☐Lying down, falling or staying asleep ☐Pulling, pushing or reaching ☐Raising arm(s) above shoulder(s)
☐Sitting in car or chair ☐Self care (dressing, bathing, etc.) ☐Working at desk/computer
☐Squatting or bending ☐Walking or running ☐Yardwork ☐Unknown

If other, please specify.

_____

17. Have you ever had any previous episodes of this condition?

☐Yes ☐No

If yes, when?

_____

18. Have you received any past care for this complaint?

☐Nothing ☐Dry Needling ☐Acupuncture ☐Chiropractic Care ☐Craniosacral Therapy
☐Homeopathic Medicine ☐Injection Therapy ☐Medical Care ☐Nutritional Supplements
☐Occupational Therapy ☐Osteopathic Medicine ☐Prescribed Medications ☐Physical Therapy
☐Surgery

If other, please specify:

_____

19. Does your pain travel anywhere else in the body?

☐Yes ☐No

If yes, please specify where.

_____

20. Do you have pain or difficulty with coughing/sneezing/bowel movements?

☐Yes ☐No

21. Select the following activities/hobbies that are difficult to perform:

☐Standing	☐Walking	☐Kneeling	☐Bending Forward
☐Getting in/out of Car	☐Sexual Activity	☐Twisting/Turning	☐Sitting/Driving/Riding
☐Using Computers	☐Using Stairs	☐Sleeping	☐Lying on Back
☐Lying on Sides	☐Lying on Stomach	☐Turning Over in Bed	☐Using Bathroom
☐Dressing Self	☐Stooping	☐Pushing/Pulling	☐Reaching
☐Lifting	☐Gripping		

If other, please specify.

_____

PAST MEDICAL HISTORY

Please fill this section out to the best of your ability.

22. Do you suffer from any other health condition(s)? Check all that apply.

☐Diabetes	☐High Blood Pressure	☐High Cholesterol	☐Asthma	☐IBS/Colitis
☐Cancer	☐Infertility Issues	☐Arthritis	☐None	☐Other

If other, please specify what.

_____

23. Do you take any prescription drugs, over-the-counter drugs, vitamins and/or supplements?

☐Yes ☐No

If yes, please specify what.

_____

24. Have you attempted any other self-care remedies to alleviate your condition? (I.e., topical ointments or home medical equipment such as braces/supports, cervical pillow, low back support belt, stretching, exercising, etc.)

☐Yes ☐No

If yes, please specify what.

_____

25. Have you had any other major illnesses, falls, hospitalizations, accidents and/or surgeries?

☐Yes ☐No

If yes, please explain.

_____

SOCIAL, WORK, HABITS

26. Occupation:

_____

Employer:

_____

27. Personal social habits:

Item	Yes	No
Smoke or use other tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

FAMILY HEALTH HISTORY

28. Please list any current or past health conditions of your family members. If deceased, indicate at what age and from what.

Mother:

_____

Father:

_____

Sister(s):

_____

Brother(s):

_____

Child(ren):

_____

If other, please specify.

_____

SYSTEM REVIEW QUESTIONS

29. Other than the condition(s) already shared, do you have any additional health concerns? (If "Yes", check box of applicable item.)

Condition	**Yes**	**No**
☐Muscles ☐Bones ☐Joints		
☐Nerves ☐Headaches ☐Dizziness ☐Emotional		
☐Head ☐Eyes ☐Ears ☐Nose ☐Throat		
☐Heart ☐Blood Pressure ☐Circulation		
☐Shortness of Breath ☐Coughing ☐Asthma ☐Lung Condition		
☐Stomach ☐Bowels ☐Digestive Condition		
☐Genital ☐Bladder ☐Urinary Condition		
☐Diabetes ☐Thyroid ☐Glandular Condition		
☐Skin ☐Bleeding Condition		
Do you have any medication allergies?		

I hereby acknowledge that all of the preceding statements are true to the best of my knowledge. I authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care.

_____ _____

Signature Date

Informed Consent: Chiropractic Care and Adjustments

I hereby request and consent to receiving **Chiropractic Manipulations (Adjustments) and other Chiropractic procedures, including various Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies** as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for **Nikolay Chiropractic** now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time and based upon the facts then known.

I also understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include but are not limited to: rest; self-administered care; over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I acknowledge that the Doctor of Chiropractic has discussed with me the following items:

- Explanation of my current condition;
- Proposed Chiropractic procedures;
- Risks of not receiving or undergoing any treatments or procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for my current condition and for any future conditions(s) for which I seek treatment. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below (for whom I am legally responsible), whether in my presence or absence.

I acknowledge that if I need to cancel an appointment, I should do so at least 24 hours in advance. I understand that a fee may be charged for a no-show or late cancellation.

Patient Name (Print)	Patient Signature	Date
Parent/Guardian/Legal Representative Name (Print)	Parent/Guardian/Legal Representative Signature	Date

X-ray Authorization

As your healthcare provider, we are legally responsible for your Chiropractic records. If it is necessary to take X-rays, we must maintain a record of your X-rays in our files. X-rays are utilized in this office to help locate and analyze vertebral subluxations. At **Nikolay Chiropractic**, the doctor(s) do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice/attention. By signing below, you are agreeing to the above terms and conditions.

Patient Name (Print)	Patient Signature	Date

Parent/Guardian/Legal Representative Name (Print)	Parent/Guardian/Legal Representative Signature	Date

FEMALE CLIENTS/PATIENTS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the X-rays are being taken at **Nikolay Chiropractic**.

Patient Name (Print)	Patient Signature	Date

Parent/Guardian/Legal Representative Name (Print)	Parent/Guardian/Legal Representative Signature	Date

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name (Print)	Patient Signature	Date
Parent/Guardian/Legal Representative Name (Print)	Parent/Guardian/Legal Representative Signature	Date

HIPAA Notice of Privacy Practices

Nikolay Chiropractic
117 W. Upham St.
Marshfield, WI 54449

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Office at 715-996-1000

Our Obligations

We are required by law to:

- Maintain the privacy of Protected Health Information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians or other personnel including people outside our office who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to any entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without a special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with the services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release health Information to the organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transportation.

Military and Veterans. If you are a member of the armed forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime or the location of the crime if victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorize persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made, if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records other than psychotherapy notes. To inspect and copy this information, you must make your request in writing to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request in writing to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to this Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Parent/Guardian/Legal Representative Name (Print)	Parent/Legal Guardian/Legal Representative Signature	Date