Confidential Patient Information

First Name _____ Last Name _____ DOB ___/___/____ Age _____

Street Address _____ SSN ____-___-_____ Gender ❑ M ❑ F

City _____ State _____ Zip code _____

Home Phone (____) ____-_____ Work Phone (____) ____-_____ Cell Phone (____) ____-_____

Email_____

Occupation _____ Employer _____

Marital Status: Children: Name/Age _____

Spouse _____ DOB ___/___/___ Occupation _____

Emergency Contact: Name _____ Phone # _____ Relation:_____

Who may we thank for referring you to our office? _____

Who is responsible for bill? ❑ Self ❑ Parent ❑ Work Comp ❑ Auto Ins. ❑ Personal Ins.

The following people are allowed access to my health information:

_____ _____ _____

Would you like to receive our monthly E-newsletter: ❑ Yes ❑ No E-mail:_____

Robinson Family Wellness Privacy Policy

I consent to the use or disclosure of my protected health information by Robinson Family Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Robinson Family Wellness. I understand that diagnosis or treatment of me by my physician(s) at Robinson Family Wellness may be conditional upon my consent as evidenced by my signature on this document. I also understand that Robinson Family Wellness will only release my protected health information to outside sources that have a specific signed release. Therefore we do not rent or sell your personal information to any outside sources.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Robinson Family Wellness is not required to agree to the restrictions that I may request. However, if Robinson Family Wellness agrees to a restriction that I request, the restriction is binding on Robinson Family Wellness and my physician(s) at Robinson Family Wellness

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Robinson Family Wellness or Robinson Family Wellness has taken action in reliance on this consent. My “protected health information” means health information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse, this includes my demographic information. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____ _____

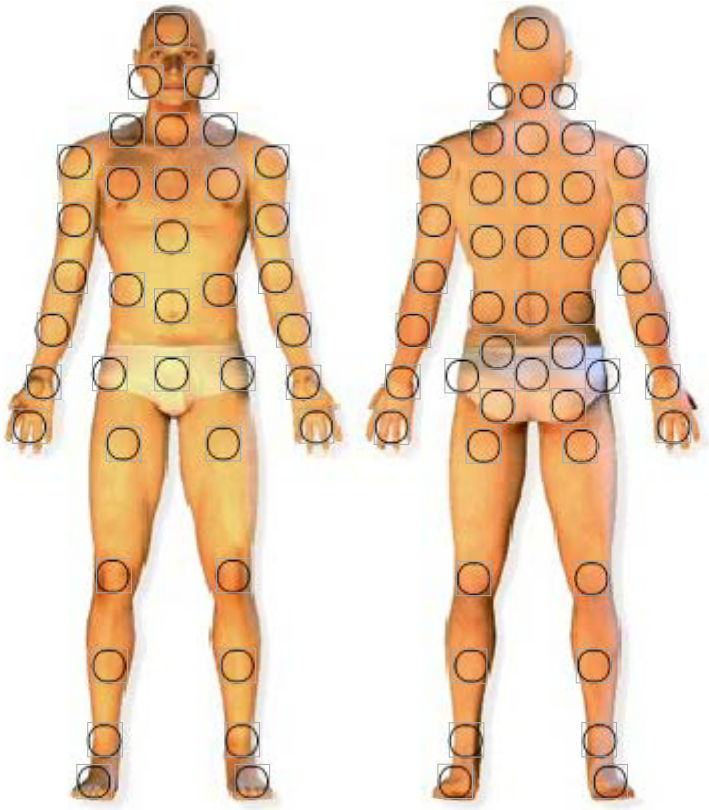
Signature of Patient or Guardian Printed Name of Patient or Guardian Date

Addressing The issue that brought you to the Office

If you have no symptoms or complaints, and are here for wellness services, please check here: ☑

Please list the reason(s) for consulting our office: _____

Please select the area(s) or your chief area of complaint.



When did this condition begin? _____

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)

At its best: _____ At its Worst: _____ Current Level: _____

Activity of daily living most affected?

❑ employment	❑ sitting	❑ traveling and/or driving
❑ homemaking	❑ sleeping	❑ walking
❑ lifting	❑ social life	❑ Other _____
❑ personal care (washing, dressing, etc.)	❑ standing	

What do you have difficulty performing due to this specific complaint? (Choose all the apply)?

❑ bending over	❑ driving car	❑ performing household chores
❑ caring for family	❑ exercising	❑ lifting objects
❑ climbing stairs	❑ getting in/out of car	❑ looking over shoulder
❑ concentrating	❑ getting to sleep	❑ lying down
❑ dressing self	❑ grocery shopping	❑ Other _____

Please describe your chief complaint

Frequency:

❑ Constant (100%-75%) ❑ Intermittent (50%-25%) ❑ Random

❑ Frequent (75%-50%) ❑ Occasional (25%-1%) ❑ Recurring

Quality:

❑ aching ❑ intolerable ❑ "shock like" ❑ throbbing

❑ burning ❑ numbing ❑ shooting ❑ "tightness"

❑ diffuse ❑ pulling ❑ stabbing ❑ tingling

❑ dull ❑ sharp ❑ "stiffness" ❑ Other _____

Change in complaint since onset:

❑ improved ❑ stayed the same ❑ not changed ❑ worsened

Discomfort decreases with: (Choose al that apply if applicable)

❑ Rest ❑ Prescription Medication ❑ Heat

❑ Chiropractic Care ❑ Movement ❑ Other _____

❑ Over the counter medication ❑ Ice

Discomfort increases with: (Choose all that apply if applicable)

❑ Almost any movement ❑ Prolonged sitting ❑ Other _____

❑ Applied pressure ❑ Coughing/sneezing

Any past episodes of this complaint? ❑ Yes ❑ No

Have you received any past care for this complaint? ❑ Yes ❑ No (Choose all that apply if applicable)

❑ acupuncture ❑ occupational therapy ❑ physical therapy

❑ chiropractic care ❑ over-the-counter medications ❑ surgery

❑ medical care ❑ prescribed medications ❑ other _____

Have any recent diagnostic images or testes been performed? ❑ Yes ❑ No

Activities of daily living most affected? (Choose all that apply if applicable)

❑ employment ❑ personal care ❑ social life ❑ driving

❑ homemaking ❑ sitting ❑ standing ❑ walking

❑ lifting ❑ sleeping ❑ traveling ❑ other _____

What do you have difficulty performing due to this specific complaint: (Choose all that apply)

❑ bending over ❑ lifting objects ❑ walking

❑ climbing stairs ❑ looking over shoulder ❑ other

❑ concentrating ❑ reaching overhead _____

❑ dressing self ❑ rising out of chair or bed

❑ driving car ❑ showering or bathing

❑ exercising ❑ sitting

❑ getting in/out of car ❑ standing

❑ getting to sleep ❑ staying asleep

❑ household chores ❑ using a computer

Allgeries: ❑ N/A

Are you allergic to any medication(s)? _____

Are you allergic to any of the following?

❑ Bee Sting	❑ Latex	❑ Peanuts	❑ Wheat
❑ Dairy	❑ Mold	❑ Pollen	❑ Other
❑ Eggs	❑ Nuts	❑ Shellfish	_____

Describe the reaction:_____

Medications: ❑ See attached list

❑ steroidal anti-inflammatory	❑ pain reliever	❑ anti-viral	❑ NSAID
❑ over-the-counter	❑ sleeping pill	❑ anti-acid	❑ mood elevator
❑ anti-depressant	❑ prescription	❑ aspirin	❑ other
❑ muscle relaxer	❑ chemotherapy	❑ codeine	_____

Surgical History: ❑ N/A

❑ abdominal aortic aneurysm repair	❑ carpal tunnel (❑ L)(❑ R)	❑ implants	❑ tonsils & adenoids
❑ appendectomy	❑ cataract (❑ L)(❑ R)	❑ knee (❑ L)(❑ R)	❑ transplant
❑ bunionectomy	❑ discectomy level	❑ Lasik	❑ wisdom teeth
❑ C-Section	❑ ear tubes	❑ mastectomy	❑ other
❑ cardiac bypass	❑ gall bladder removed	❑ shoulder (❑ L)(❑ R)	_____
❑ cardiac valve replacement	❑ ganglion cyst	❑ spinal fusion	
	❑ gastric bypass	❑ thyroidectomy	
	❑ hysterectomy	❑ tonsils	

History of Pregnancy: ❑ N/A

Are you currently pregnant? ❑ Yes ❑ No Due Date: ___/___/_____

Date of last menstrual period:___/___/_____ Number of pregnancies:_____ Number of deliveries: _____

Family History:

❑ diabetes	❑ anorexia	❑ high cholesterol
❑ cancer	❑ arthritis	❑ kidney disease
❑ hypertension	❑ asthma	❑ liver disease
❑ congenital anomaly - _____	❑ bleeding disorders	❑ multiple sclerosis
❑ hereditary disorder - _____	❑ chemical dependency	❑ osteoarthritis
❑ neuromuscular issues - _____	❑ depression	❑ osteoporosis
❑ AIDS/HIV	❑ diabetes	❑ Parkinson's disease
❑ alcoholism	❑ emphysema	❑ prostate problems
❑ Alzheimer's	❑ epilepsy	❑ rheumatoid arthritis
❑ anemia	❑ heart disease	❑ stroke
	❑ hepatitis	❑ thyroid problems
	❑ high blood pressure	❑ other _____

Accidents:

❑ no previous trauma reported
❑ automobile accident
❑ slip and fall
❑ motorcycle accident
❑ resulting in fracture(s) - _____
❑ resulting in permanent injury or disability - _____
❑ resulting in hospitalization(s) - _____
❑ resulting in sprains/strains
❑ resulting in loss of consciousness
❑ other _____ _____

Work Habits:

❑ no change in work habits since condition began
❑ cannot work due to presenting condition
❑ permanently fully disabled
❑ permanently partially disabled

❑ full-time ❑ part-time

❑ homemaker ❑ retired ❑ student ❑ unemployed

❑ 0 to 20 hrs per week ❑ 40 to 50 hours per week ❑ 60 to 70 hours per week
❑ 20 to 40 hours per week ❑ 50 to 60 hours per week ❑ over 70 hours per week

❑ mostly sitting ❑ mostly standing ❑ mostly walking

❑ light labor ❑ moderate labor ❑ heavy labor ❑ sedentary
❑ computer ❑ repetitive ❑ telephone

Social Habits:

❑ Does not smoke, drink alcohol, or take rec. drugs

❑ does not drink alcohol ❑ is a light drinker ❑ is a heavy drinker ❑ is a recovering alcoholic
❑ is a social drinker ❑ is a moderate drinker ❑ is an alcoholic

❑ current every day smoker ❑ ex-smoker ❑ light tobacco smoker
❑ current some day smoker ❑ heavy tobacco smoker ❑ never smoked tobacco

❑ does not drink caffeine ❑ drinks 2 to 4 cups of caffeine per day
❑ drinks 1 cup of caffeine in the morning ❑ drinks 5 or more cups of caffeine per day

❑ does not use recreational drugs ❑ moderate use of recreational drugs
❑ light use of recreational drugs ❑ heavy use of recreational drugs
❑ is drug addicted and is a recovering drug addict.

Exercise Habits:

❑ none ❑ every other day ❑ once a week
❑ daily ❑ few times a week ❑ almost nothing

❑ aerobic ❑ stretching ❑ strength

Diet and Nutrition:

❑ restricted ❑ unrestricted (2-3 meals per day)

❑ reports eating too little ❑ binges
❑ reports eating too much ❑ purges

Detailed Review of Systems

Patient Name_____ Date_____

CARDIOVASCULAR ❑ N/A

Present	Past	
❑	❑	Poor Circulation
❑	❑	High Blood Pressure
❑	❑	Aortic Aneurysm
❑	❑	Heart Disease
❑	❑	Heart Attack
❑	❑	Chest Pain
❑	❑	High Cholesterol
❑	❑	Pacemaker
❑	❑	Jaw Pain
❑	❑	Irregular Heartbeat
❑	❑	Swelling of Legs
❑	❑	Stroke

GENITOURINARY ❑ N/A

Present	Past	
❑	❑	Kidney Disease
❑	❑	Lower Side Pain
❑	❑	Burning Urination
❑	❑	Frequent Urination
❑	❑	Blood in Urine
❑	❑	Kidney Stone
❑	❑	Bed Wetting/Enuresis
❑	❑	Prostate Problems
❑	❑	Rectal Prolapse

HEMATOLOGICAL/LYMPHATIC ❑N/A

Present	Past	
❑	❑	Poor Circulation
❑	❑	High Blood Pressure
❑	❑	Aortic Aneurysm
❑	❑	Heart Disease
❑	❑	Heart Attack
❑	❑	Chest Pain
❑	❑	High Cholesterol
❑	❑	Pacemaker
❑	❑	Jaw Pain
❑	❑	Irregular Heartbeat
❑	❑	Swelling of Legs
❑	❑	Stroke

RESPIRATORY ❑ N/A

Present	Past	
❑	❑	Asthma
❑	❑	Shortness of Breath
❑	❑	Upper Resp. Infection
❑	❑	Cold/Flu
❑	❑	Pneumonia
❑	❑	Cough/Wheezing
❑	❑	Emphysema
❑	❑	RSV
❑	❑	Tuberculosis

EAR/NOSE/THROAT ❑ N/A

Present	Past	
❑	❑	Sinus Congestion
❑	❑	Sinus Infection
❑	❑	Nosebleed
❑	❑	Sore Throat
❑	❑	Difficulty Swallowing
❑	❑	Ear Ache
❑	❑	Ear Infections
❑	❑	Dizziness
❑	❑	Hearing Loss
❑	❑	Bleeding Gums

EYES ❑ N/A

Present	Past	
❑	❑	Glaucoma
❑	❑	Double Vision
❑	❑	Blurred Vision
❑	❑	Red, Itchy (Allergy)

ALLERGIC/IMMUNOLOGICAL ❑ N/A

Present	Past	
❑	❑	Autoimmune Disorder
❑	❑	Chronic Allergies
❑	❑	Seasonal Allergies
❑	❑	Food Allergies
❑	❑	Environmental Allergies
❑	❑	Allergy Shots
❑	❑	Cortisone Use
❑	❑	HIV/AIDS
❑	❑	Hives
❑	❑	Weak Immune System

GASTROINTESTINAL ❑ N/A

Present	Past	
❑	❑	Pancreatitis
❑	❑	Acid Reflux
❑	❑	Bowel Problems
❑	❑	Constipation
❑	❑	Upset Stomach
❑	❑	Gas Pains
❑	❑	Ulcers
❑	❑	Gallbladder Problems
❑	❑	Liver Problems
❑	❑	Diarrhea
❑	❑	Nausea/Vomiting
❑	❑	Poor Appetite
❑	❑	Bloody Stools
❑	❑	Crohn's Disease
❑	❑	Hiatal Hernia

MUSCULOSKELETAL ❑ N/A

Present	Past	
❑	❑	Chronic Hip Dislocation
❑	❑	Torticollis
❑	❑	Poor Posture
❑	❑	Neck Pain
❑	❑	Back Pain
❑	❑	Arthritis
❑	❑	Rheumatoid Arthritis
❑	❑	Joint Stiffness
❑	❑	Muscle Weakness
❑	❑	Osteoporosis
❑	❑	Broken Bones
❑	❑	Joint Replacement
❑	❑	Gout

NEUROLOGICAL ❑ N/A

Present	Past	
❑	❑	Tic Disorder
❑	❑	Seizures
❑	❑	Head Injury
❑	❑	Brain Aneurysm
❑	❑	Numbness/Tingling
❑	❑	Pinched Nerves
❑	❑	Radiating Pain
❑	❑	Sciatica
❑	❑	Parkinson's Disease
❑	❑	Carpal Tunnel

NEUROLOGICAL CONTINUED...

❑	❑	Balance/Coordination
❑	❑	ADHD/ADD/Sensory Processing Disorder
❑	❑	Autism/Spectrum Disorder
❑	❑	Migraine Headaches
❑	❑	Bell's Palsy
❑	❑	Poor Fine/Gross Motor Skills
❑	❑	Epilepsy
❑	❑	Inflammation
❑	❑	Trigeminal Neuralgia
❑	❑	Ear Ringing/Tinnitus
❑	❑	Auditory Processing
❑	❑	Toe Walking
❑	❑	Sinus Headache
❑	❑	Tension Headache
❑	❑	Vertigo/Dizziness
❑	❑	Sensory Integration

ENDOCRINE ❑ N/A

Present	Past	
❑	❑	Hyperthyroid Issues
❑	❑	Hypothyroid Issues
❑	❑	Type 1 Diabetes
❑	❑	Type 2 Diabetes
❑	❑	Hair Loss
❑	❑	Menopausal
❑	❑	Menstrual Problems
❑	❑	Hot Flashes
❑	❑	Endometriosis
❑	❑	Polycystic Ovarian Syndrome
❑	❑	Hashimoto
❑	❑	Graves

PSYCHIATRIC ❑ N/A

Present	Past	
❑	❑	Depression
❑	❑	Anxiety Disorder
❑	❑	Unusual Stress
❑	❑	OCD
❑	❑	Bipolar Disorder
❑	❑	Seasonal Affective Disorder
❑	❑	Mood Swings
❑	❑	Social Anxieties
❑	❑	Memory Loss
❑	❑	Night Tremors

CONSTITUTIONAL ❑ N/A

Present	Past	
❑	❑	Weight Loss/Gain
❑	❑	Energy Level Low
❑	❑	Energy Level High
❑	❑	Difficulty Sleeping
❑	❑	Chronic Fatigue
❑	❑	General Malaise
❑	❑	Compulsive Behavior
❑	❑	Behavior Issues
❑	❑	Learning Disabilities
❑	❑	Speech Delays
❑	❑	RLS
❑	❑	Pregnancy/Fertility
❑	❑	Obesity

Robinson Family Wellness Patient Financial Policy

The goal of Robinson Family Wellness is to render care within our realm of expertise to stimulate your innate ability to heal. We will give 100% of our energy to accomplish this and do our best to prevent financial constraints from interfering with your ability to receive care. To prevent misunderstandings about the financial aspects of care, the following discloses our financial policy.

PATIENTS WITH INSURANCE COVERAGE

For those patients who have insurance coverage, we will verify your insurance benefits to see if chiropractic care is covered and any limitations that exist. We will explain this to you, and then bill the insurance for the services provided. You are expected to pay your "co-pay" and any portion that your insurance doesn't cover **on the date of service.** If, for some reason, your insurance does not pay for a particular charge, those charges are then your responsibility. It is therefore prudent for you to understand your insurance policy and contact your insurance promptly with any questions or concerns. We do reserve the right to no longer bill your insurance company if that company is unreasonably difficult to work with.

PATIENTS PAYING OUT OF POCKET/ "CASH" PATIENTS

Cash, checks, and credit cards are accepted, and payment is expected at the time of service. We also have affordable payment options. Please ask at the front desk staff what options may be available to you.

PATIENTS WITH AUTO/WORKER'S COMPENSATION CLAIMS

For patients under care relative to an automobile accident or injury on the job, insurance will cover the cost of care in most cases. We are required to bill *your* auto insurance (or the insurance of the driver of the vehicle in which you were riding) or your WC insurance. Nutritional supplements and some orthopedic equipment, if recommended, are not paid for by insurance and are the patient's financial responsibility. If/when your insurance discontinues paying for your treatment, **you are then responsible for payment** of your care. If necessary, a payment plan may be arranged. If you decide to get legal aid, we will hold payment until settlement of your claim as long as you are using one of the attorneys we strongly recommend.

CANCELLATION POLICY

If you must miss your scheduled appointment, it is best to reschedule as soon as possible. We have a **24 hour cancellation policy**. A fee equal to the fee of the appointment will be incurred if we do not receive advanced notification of at least 24 hours. Insurance does not cover this fee. It will be your responsibility.

OUTSTANDING BALANCE POLICY

Patients will receive a monthly fee of $5 if their account has a balance that is 90+ days overdue and no payments are being made on it. Overdue accounts will not receive this fee if regular payments are being made to the account. If no payment is made after 180+ days, we unfortunately will need to send the account to collections. Please speak to the office manager if you have any concerns regarding this policy.

I have been informed of and understand this financial policy and agree to its terms. I understand that unless specific arrangements are made with Robinson Family Wellness, I am responsible for any balance acquired on this account. I understand that if I discontinue care, all charges are due and payable immediately.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

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