# New Patient Information

Taulman Chiropractic
your path to wellness

Date: _____

Name: _____ DOB: _____ Age: _____/ Male Female

Address: _____ City: _____ State: ____ Zip: _____

Home # (  )_____ Cell: (  )_____ Cellular Provider: _____

Email address: _____ Status: Single Married Partnered Divorced Widowed

Spouses name:_____ Women Only: Pregnant? Yes No

Names/Age of children:_____ _____

Occupation: _____ Employer Name/Address: _____

Who may we thank for referring you? _____

## Rate your health and wellness.

Place an '**X**' that denotes where you believe is your current level of wellness.
Place an '**O**' indicating where you would like your wellness to be.


**YOUR HEALTH PROFILE**

| Please list your health concerns. | **Rate:** Severity 1=Mild 10= Worst | When did this episode start? | Have you had this issue before? When? | **Sensation:** i.e. sharp, burning | % of the time pain is present | R Side, L Side Both | **Issue:** Same, better, or worse since it began? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

- Did problem begin with an injury? How? _____
- What makes the problem worse?_____
- What, if anything, makes the problem feel better?_____

- On a scale of 1-10 please rate the condition that interferes with the following:

Condition _____ ___Leisure ___Work ___Sleep ___Sports ___Other

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# Your Wellness History – Health Profile, page 2

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➢Have you seen other doctors for this condition? ___ Chiropractor ___ MD ___ Other: _____

Dr. Name/Address: _____ Date: _____

What was the diagnosis:_____

➢Have you had an x-ray, MRI or CT Scan in the past year? _____ Area of body? _____

➢Please list all medications you are taking, and why; (Prescription and non-prescription)

_____

_____

_____

➢Please list all nutritional supplements, vitamins, and homeopathic remedies that you presently take and why:

_____

_____

_____

➢ Have you had any surgeries and/or hospitalizations? ____Yes ____No

If yes, briefly explain:_____

_____

_____

➢Have you ever had any work related injuries? ____Yes ____No

If yes, briefly explain: _____

_____

_____

➢Have you ever had any slips, falls or auto accidents? ____Yes ____No

If yes, briefly explain:_____

_____

_____

➢On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: _____

Scale =____ Personal stress: _____

➢On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating _____ Exercise _____ Sleep _____ General Health _____ Wellness lifestyle _____

# Your Wellness History – Health Profile, page 3

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Please check all symptoms (now or in the past) you have ever had, even if they do not seem related to your current problem.

| Current | Past | | Current | Past | | Current | Past | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Headaches/Migraines | ❑ | ❑ | Irritability | ❑ | ❑ | Scoliosis |
| ❑ | ❑ | Pins & needles in arms | ❑ | ❑ | Cold hands | ❑ | ❑ | Asthma |
| ❑ | ❑ | Pins & needles in legs | ❑ | ❑ | Cold feet | ❑ | ❑ | Seizures |
| ❑ | ❑ | Dizziness | ❑ | ❑ | Fever | ❑ | ❑ | Sinus Issues |
| ❑ | ❑ | Numbness in fingers | ❑ | ❑ | Urinary problem | ❑ | ❑ | Diabetes |
| ❑ | ❑ | Fatigue | ❑ | ❑ | Fainting | ❑ | ❑ | Heart Disease |
| ❑ | ❑ | Sleeping problems | ❑ | ❑ | Eyes bothered by light | ❑ | ❑ | Allergies |
| ❑ | ❑ | Tension | ❑ | ❑ | Stomach upset | ❑ | ❑ | Epilepsy |
| ❑ | ❑ | Ulcers | ❑ | ❑ | Diarrhea | ❑ | ❑ | Arteriosclerosis |
| ❑ | ❑ | Buzzing in ears | ❑ | ❑ | Cold sweats | ❑ | ❑ | Cancer |
| ❑ | ❑ | Ringing in ears | ❑ | ❑ | Mood swings | ❑ | ❑ | High Blood Pressure |
| ❑ | ❑ | Numbness in toes | ❑ | ❑ | Loss of smell | ❑ | ❑ | Stroke |
| ❑ | ❑ | Depression | ❑ | ❑ | Loss of taste | ❑ | ❑ | Nervousness |
| ❑ | ❑ | Constipation | ❑ | ❑ | Back pain | ❑ | ❑ | Gout |
| ❑ | ❑ | Menstrual pain | ❑ | ❑ | Neck pain | ❑ | ❑ | Arthritis |
| ❑ | ❑ | Menstrual irregularity | ❑ | ❑ | Stiff neck | ❑ | ❑ | Low Blood Sugar |

Please check all that are relevant.

Do you:

- ❑ Drink Water - ½ your body weight in ounces
- ❑ Exercise regularly
- ❑ Take vitamins or supplements

Would you like to know more about:

- ❑ Proper Nutrition and meal planning
- ❑ Proper exercise routines and techniques
- ❑ How to deal with LifeStyle stress

Expectations

- ❑ Become pain free
- ❑ Explanation of my condition
- ❑ Learn how to care for this condition on my own
- ❑ Reduce Symptoms
- ❑ Resume Normal Activity

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| | |
|---|---|
| Consultation | Free |
| New Patient Examination | $90 |
| Radiographs (x-ray) | $80 |
| Adjustment | $42 |
| Re-examination after 12 visits | $25 |

I have elected to use the following payment plan to finance my care at Taulman Chiropractic Family Wellness:

- ☐ Cash/MasterCard/Visa/Discover – Payment is due at time of service.
- ☐ Insurance Policy/HSA coverage – Although I am totally responsible for charges I may incur in this office. I will initially pay for my yearly deductible and co-payments for each visit. If my insurance fails to pay its share, I will be responsible for paying my balance in full. I will notify the front desk of any changes in policy coverage.
- ☐ Medicare/Medicare Replacement Plans – Payment is due at time of service. Taulman Chiropractic will assist in completing Medicare forms on my behalf. Medicare may only cover chiropractic adjustments for acute care.
- ☐ Pre-Pay Plans Save $$$
- ☐ Auto Accident/Workers Compensation

Note: Taulman Chiropractic will refund any overpayments made to us upon completion of care. The patient agrees that they are responsible for all bills incurred at this office, as well as court costs, attorney fees, and/or collection fees.

**Practice's Privacy Requirements**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. It is our policy to remind patients of their appointments. We may do this by telephone, email, mail, or by any means convenient for the practice and/or as requested by you. We agree to provide patients with access to their records in accordance with state and federal laws. We may have to change, add, delete or modify any of these provisions to better serve the needs of both practice and patient. More information can be found and listed under our privacy practices. Please ask the staff for a copy and we will provide one to you.

Thank you for filling out this form.
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date. Should my account be referred for collection, I agree that I am responsible for fees associated with the collection of the unpaid balance from our office and/or our outside services including, but not limited to collection fees up to thirty five percent of the delinquent balance, attorney's fees, and court costs. I agree to pay a $25.00 fee for all returned checks which sum shall be added to the account balance. I acknowledge that if an account is referred to collection with this fee, the fee will be included in calculating the collection fees.
I have read and fully understand the Terms of Acceptance and Payment Policy:

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.