

CONFIDENTIAL PATIENT HEALTH HISTORY RECORDS

Date: ___/___/___

Name:(First) _____ (M) _____ (Last) _____ Nick Name: _____

Address: _____ **City:** _____ **ST:** ___ **Zip:** _____

Home (____) _____ **Cell** (____) _____ **Sex:** M F OTHER _____

(*Please note:* If no phone, provide an alternative emergency phone number) **Marital Status:** M S D W

DOB: ___/___/___ **AGE:** _____ **SS#** _____ - _____ - _____ (**Confidential information is not shared**)

Military: Yes No (*Years in Service:* _____) **Prefer Appointment Reminder Method:** Call Text Opt Out

Occupation: _____ **Employer:** _____ **Yrs/Mths** _____ **Phone:** _____

Spouse: _____ **Phone:**(____) _____ **Employer:** _____

Emergency Contact: Spouse Parent Other Name: _____ **Phone:**(____) _____

Primary Care Doctor: _____ **Clinic:** _____

Phone (____) _____ **Date Last Seen:** ___/___/___ **For:** _____

Education Level: Some High school (____ Years) High School Graduate (____ Year)
 Tech School (____ Years _____ DGR) College (____ Years _____ DGR)

If A Minor Parents Name: Mother: _____ Father: _____ Guardian: _____

Insurance

I wish to pay for services out of pocket and not have an insurance billed. Yes (Cash, Check, Credit Card)

Primary Insurance Provider: _____ **Health Savings:** Yes No

Main Policy Carrier: Self Spouse Parent Other (Name _____ DOB _____)

Supplemental/Union Provider: _____

Main Policy Carrier: Self Spouse Parent Other (Name _____ DOB _____)

Initial Complaint

What is your primary medical issue or concern?

When did your symptoms appear? _____

Work related? Yes No **Date of Injury:** _____ **Auto Accident** Yes No **Date of Injury:** _____

Can you explain what you feel may have caused your symptoms?

Are your symptoms: Getting worse? Getting better? Same Comes and Goes

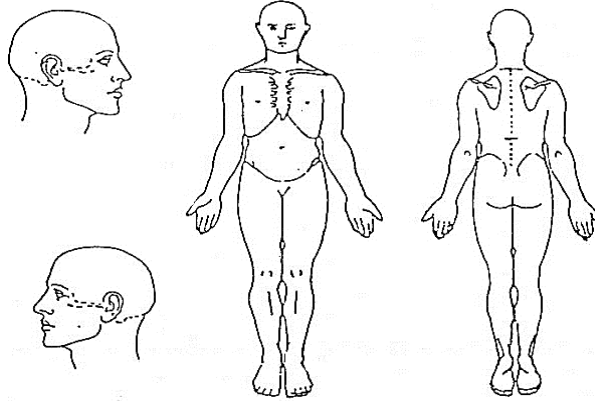
What treatment have you already received for your condition? Medications Surgery Massage Therapy
 Physical Therapy Chiropractic None Other _____

Other doctor(s) and dates that treated you for this condition: _____

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Place the appropriate symbols to mark the areas of discomfort you are experiencing.

- XXX** BURNING (BU)
- (((** ACHING PAIN (AC)
- OOO** PINS & NEEDLES (PI)
- :::** NUMBNESS (NU)
- ///** SHARP PAINS (SH)



For Office Use Only

Constant Better

Come/Go Worse

Worse Same

Better: Worse:

_____ AM _____

_____ MIDDAY _____

_____ PM _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) 0 1 2 3 4 5 6 7 8 9 10 |

Does it interfere with: Work Sleep Daily Routine Recreation

Activities or movements that is painful to perform:

Sitting Standing Walking Bending Lying Down Getting Out of Chair Other _____

Other comments or concerns regarding your condition:

Review of symptoms (Check Symptoms and The Corresponding Side of Symptom)

General

- | | | | | |
|--|------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sweats | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Light Headaches | <input type="checkbox"/> Tremors | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Other _____ |

How often do you have this pain? +75% constant 50-75% Frequent 25-50% Occasional <25% Intermittent

Neck

Pain in Neck (L or R) Neck Stiffness Muscle Spasms in Neck Popping/Grinding Sounds in Neck

How often do you have this pain? +75% constant 50-75% Frequent 25-50% Occasional <25% Intermittent

Mid Back:

Pain Between Shoulder Blades Mid Back Muscle Spasms Pain Around Ribs

Pain on Deep Breathing Other _____ Other _____

How often do you have this pain? +75% constant 50-75% Frequent 25-50% Occasional <25% Intermittent

Low Back:

Low Back Pain (L / R) Pain in Buttock (L / R) Pain In Hip (L / R)

Pain Down Leg (L / R) Numbness of Leg (L / R) Numbness of Feet (L / R)

Numbness of Toes (L / R) Leg Cramp (L / R) Knee Pain (L / R)

Ankle Pain (L / R) Pins and Needles in Leg (L / R) Swollen Ankle (L / R)

Foot Pain (L / R) Groin Pain Other _____

Worse When: Lifting Stooping Sitting Standing Coughing Bending

How often do you have this pain? +75% constant 50-75% Frequent 25-50% Occasional <25% Intermittent

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Shoulders/Arms/Hands:

- | | |
|---|---|
| <input type="checkbox"/> Pain in Shoulder Joint (L / R) | <input type="checkbox"/> Can't Raise Arms Above Shoulder level (L / R) |
| <input type="checkbox"/> Tension in Shoulder (L / R) | <input type="checkbox"/> Pain in Upper Arm (L / R) |
| <input type="checkbox"/> Numbness in Upper Arm (L / R) | <input type="checkbox"/> Pain in Forearm (L / R) |
| <input type="checkbox"/> Numbness in Fore Arm (L / R) | <input type="checkbox"/> Sensation of Pins and Needles in Forearm (L / R) |
| <input type="checkbox"/> Pain in Hands or Fingers (L / R) | <input type="checkbox"/> Fingers Go to Sleep (L / R) |
| <input type="checkbox"/> Swollen Hands or Fingers (L / R) | <input type="checkbox"/> Loss of Grip Strength (L / R) |
| <input type="checkbox"/> Elbow Pain (L / R) | <input type="checkbox"/> Wrist Pain (L / R) |
| <input type="checkbox"/> Hand Pain (L / R) | <input type="checkbox"/> Hand Numbness (L / R) |
| <input type="checkbox"/> Sensation of Pins and Needles in Hands (L / R) | <input type="checkbox"/> Other _____ |

How often do you have this pain? +75% constant 50-75% Frequent 25-50% Occasional <25% Intermittent

Cardiovascular:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Pain Over Heart |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Slow Heart Beat | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Arrhythmia |
-

Eyes/Ears/Nose/Throat:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Deafness | <input type="checkbox"/> Earache/Noises | <input type="checkbox"/> Ear Discharge |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Failing Vision |
| <input type="checkbox"/> Gum Trouble | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Belching or Gas | <input type="checkbox"/> Nasal Obstruction |
-

Respiratory:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Difficult to Breathe | <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Spitting Blood |
| <input type="checkbox"/> Spitting up Phlegm | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Other _____ | | |
-

GENITO/URINARY:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Inability to Control Bladder |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Kidney Infections or Stones | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Lumps in Breast | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Other _____ | | | |
-

GASTROINTESTINAL:

- | | | | | |
|-----------------------------------|--|---|--|--|
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficult Digestion |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Intestinal Worms | <input type="checkbox"/> Nausea | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Pain Over Stomach | <input type="checkbox"/> Distention of Abdomen |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive Bowel Gas | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Other _____ | |
-

Please provide any additional information you want the doctor to know:

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Pediatrics (For children 12 and under)

Child birth was: Vaginal Birth C-Section **Was the child:** Early (How early: _____) Late (How late: _____)

Please check any that apply: Breech Induction Vacuum Extraction Forceps Other _____

Childs birth weight: _____ LBS. _____ OZ **Height:** _____ IN **Is/Was** Breastfed Formula Cow/Goat Milk

Does child ever suffer from: Colic Reflux Ear Infection Constipation Allergies Difficulty Feeding

Fevers Trouble Sleeping Trouble Crawling Excessive Crying Rashes Slow Learning Hearing

Anything else you want the doctor to know: _____

History

Date of most resent:

Physical Exam X-Ray: ____/____/____ Spinal Exam: ____/____/____ MRI, CT or Bone Scan: ____/____/____

Past surgeries: _____

Past Accidents or Injuries: _____

List medications? _____

Have you seen a chiropractor before? Yes No Dr. Name: _____

Reason: _____

Not yourself, Immediate/Extended Family Health: Father Mother Grandparent Other

Heart Related (Type _____) _____

Cancer (Type _____) _____

Thyroid (Type _____) _____

Stroke (Type _____) _____

Kidney (Type _____) _____

Immune Disorder (Type _____) _____

Blood Pressure (Type _____) _____

Diabetes (Type _____) _____

Depression (Type _____) _____

Other (Type _____) _____

Personal Habits

EXERCISE

None

Moderate

Daily

Heavy

WORK

Sitting

Standing

Light Labor

Heavy Labor

SOCIAL HABITS

Smoking (Packs/Day _____)

Alcohol (Drinks/Week _____)

Coffee/Caffeine Drinks (Cups/Day _____)

High Stress (Reason _____)

Are you potentially or currently pregnant? Yes No Due Date ____/____/____ # Of Children: _____

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PLEASE FILL SECTION 1 OR 2 IF APPLICABLE. OTHERWISE SKIP TO SIGNATURE:

1. MEDICAL REPRESENTATIVE INFORMATION

Please fill out if person is unable to make medical choices for themselves and needs a legal representative on file.

I have _____ representative that handles my Medical and Financial accounts. Phone: H _____ C _____

2. AUTHORIZATION TO TREAT A MINOR

Please fill out for children 17 and under and only parent or guardian sign.

I _____ HEREBY AUTHORIZE DR STEVEN J FELICIJAN TO ADMINISTER CHIROPRACTIC CARE AS HE DEEMS NECESSARY TO MY SON/DAUGHTER

DATED AT PARDEEVILLE, WI ON THIS _____ DAY OF _____, 20 _____.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL THE ABOVE STATEMENT'S ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORIZATION FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT SO APPROVED.

X

PRINT FULL NAME

X

TODAYS DATE

X

Patient/Guardian Signature

OFFICE PERSONAL

DATE: ___/___/____

VERIFIED STAFF SIGNATURE: _____

CONFIDENTIAL PATIENT HEALTH RECORDS

Financial Policy

Please read carefully and Felicijan Chiropractic Office will help you with any questions you may have. Felicijan Chiropractic Office strives to provide the highest quality health care, all the while maintaining affordability for you, the patient. Felicijan Chiropractic Office understands that even with insurance, most patients will experience at least some out of pocket expense. Please provide any primary, secondary insurance or union participation card at time of visit.

Participating Insurances

Felicijan Chiropractic Office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Felicijan Chiropractic Office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. As a courtesy Felicijan Chiropractic Office will file your claims for you and assist you in every way possible to ensure benefit recovery. Felicijan Chiropractic Office cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. Felicijan Chiropractic Office will contact your insurance provider to verify your policy benefits; however, the benefits quoted to Felicijan Chiropractic Office by your insurance company are not a guarantee of payment. It is Felicijan Chiropractic Office policy that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays at time of service in full.

Non Participating Insurances

Felicijan Chiropractic Office is not a participating provider with your current insurance company, therefore payment may be requested at time of service. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Felicijan Chiropractic Office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. As a courtesy Felicijan Chiropractic Office will file your claims for you and assist you in every way possible to ensure benefit recovery. Felicijan Chiropractic Office cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. Felicijan Chiropractic Office will contact your insurance provider to verify your policy benefits; however, the benefits quoted to Felicijan Chiropractic Office by your insurance company are not a guarantee of payment. It is Felicijan Chiropractic Office policy that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays at time of service in full.

Work Compensation/Auto Accident

You will be responsible for bringing in insurance information regarding your WC/Auto accident. Present all forms (employer/medical/accident report) and adjustor's information that pertain to the incident. You are responsible for informing your employer/insurance ahead of time. Most payments will come directly to Felicijan Chiropractic Office but if not, you will be responsible for full payment at time of service. An Attorney Lien will be signed on the start of your care in auto accidents. If a third party insurance is involved, you will pay services on the same day as care. All Doctor's notes will be submitted along with billing. Whatever expenses that are not paid by the insurance will be your responsibility. If you wish to submit rendered services to your personal health insurance after Felicijan Chiropractic Office has billed the initial auto insurance, Felicijan Chiropractic Office will be more than happy to supply information needed to bill yourself. Benefit coverage is not guaranteed therefore if we do not receive payment after claims have been billed, the

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rendered balance is your responsibility. Felicijan Chiropractic Office will consider sending claims to collections if not resolved within a 90 day period after all avenues exceeded.

Patients without Insurance

Felicijan Chiropractic Office request that **100%** of the services (examination, x-ray, etc...) be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. Felicijan Chiropractic Office is happy to accept cash, check, and credit card. No insurance will be billed.

Medicare

Felicijan Chiropractic Office **does not** accept assignment from Medicare. Reimbursement is sent to you directly in payment for chiropractic services that Medicare will cover and you are expected to pay at time of service. Medicare will **ONLY** cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services which Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Supplemental/Union Insurance

Please inform Felicijan Chiropractic Office of any secondary insurance you may have. Felicijan Chiropractic Office will file and collect from your secondary insurance for services covered by the secondary payer. Some secondary insurance will send payment to patient in which you will be responsible for paying charges at time of service.

Office Policy

Please read the following regarding assignments:

At the beginning of your treatment in Felicijan Chiropractic Office will verify your policy benefits. However, internet, phone or fax verification of coverage is never a guarantee of payment.

1. Returned checks and balances over 90 days may be subject to additional collection fees and interest charges of **18%** per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.
2. Your insurance will be filed as a courtesy to you. Felicijan Chiropractic Office files insurance claims on a weekly basis.
3. You will be responsible for your full deductible and co-payment or coinsurance. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are of aware of the denial.
4. If you pay the full amount for services rendered each visit, you may qualify for our Time of Service (TOS) discount. You may then submit the bill to your insurance company for reimbursement.
5. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within **ninety (90) days** of submission, you are responsible for payment of any outstanding balance.
6. Our fees are considered usual and customary by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

I _____ understand and agree with the statement above and acknowledge my responsibility.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____