Schantz Chiropractic, P.C.
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NEW PATIENT GET-TO-KNOW-YOU FORM *(please print or complete on-line)*

First Name:______________________M.I._____Last Name:_________________________

Preferred Name:___________________

Address:____City:________________________

State:______Zip:__________

Birthdate:______/______/______ Age_______ Gender: □ Male □ Female □ other ____________

Cell Phone:__________________________ Secondary Phone:________________________

Email:____

(We use text-message appt. reminders & e-mails for practice updates and alerts. You may opt-out any time.)

Marital Status: (check one) □ Single □ Married □ Other __________________

Children?: □ Yes □ No How Many:______

Preferred Language(s)____

Occupation:_______________________

Employer:________________________ or School (if full-time student) ________________

City _____________________ State _________

Emergency Contact: Name __________Relationship _____ Address __________Phone __________

Parents/Guardians (for minors) Name(s) _______________ Address(es)____________ Phone(s) __

How did you find out about our practice? □ Word-of-mouth □ Internet search □ Insurance plan

□ Health care provider □ other___________.

Who should we thank for referring you? ________________________________.

Initial___________

REASON FOR VISIT

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Sciatica □ Hip/Knee or Foot Pain

□ Shoulder/Arm/Wrist Pain □ Joint/Nerve Disturbance □ Stress Disorder □ Wellness Care

□Other ___________________________

List any events, conditions or activities that may have contributed to your complaints?

____

When did this complaint begin? ______/______/______ Is it getting worse? □ Yes □ No □ Constant

□ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes",
when?____

On the scale below, please circle the severity of your main complaint right now:

Mild (1 2 3) Moderate (4 5 6) Severe (7 8 9) Unbearable (10)

What aggravates this complaint(s)? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs /Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward Bending backward / Twisting / Reaching /Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:____

What relieves this complaint(s)? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching/ Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_______________________

Which of these activities are compromised by this complaint(s)?: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel /Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:__________________

List any other physicians or healthcare professionals that you have seen for these problems.

_____________________ _______________________ ___________________ ________________

Initial___________

Have any of these symptoms emerged since the onset of your complaint(s)?

Double Vision ☐Yes ☐No Difficulty Walking or Balancing ☐Yes ☐No

Dizziness/Vertigo ☐Yes ☐No Difficulty Speaking or Swallowing ☐Yes ☐No

Passing Out ☐Yes ☐No Numbness on one entire side of body ☐Yes ☐No

Nausea/Vomiting ☐Yes ☐No

CHIROPRACTIC CARE: □ None □ Infrequent □ Occasional □ Frequent. Chiropractic techniques that you favor? □ Traditional (twist/ crack) □ Instrument (No twist/crack) □ Cox® Technic □ other ____________

ACCIDENTS & INJURIES **DISEASES & MEDICAL CONDITIONS**

____
____

____
____

SURGERIES & MEDICAL PROCEDURES **HOSPITALIZATIONS & TREATMENT PROGRAMS**

____
____

____
____

List current prescription medications, OTC medicines, nutritional supplements. □ none.

1. 5.

2. 6.

3. 7.

WOMEN ONLY: Currently Pregnant? □ Yes □ Unsure □ No. Menopause? □ No □ Unsure □ Yes

SOCIAL HISTORY

Physical activity level? □ Infrequent □ Light □ Moderate □ Strenuous □ Competitive.

Do you currently smoke or use tobacco of any kind? □ Yes □ No □ Never

Are alcohol and/or substance abuse becoming any issue for you? □ no □ maybe □ yes

What is your current stress level? □ Mild □ Moderate □ High □ Worst Ever

Initial___________

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance: □ Health □ Traditional Medicare (Part B) □ Medicare Advantage (Part C)

□ Med-Pay Automobile Coverage □ Other ___________

Primary Insurance Carrier:_______________________________

Policy#_________________ Group #_____________ Claim# (for Auto or Work Comp.)__________________

Name of Policy Holder:________________________ Relationship to Patient:____________

ASSIGNMENT/AUTHORIZATION/RELEASE *(check one box & sign please)*

□ **Health/*Medicare Advantage (Part C) /Automobile Med-Pay/Special Assignment.** I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Schantz Chiropractic, P.C., all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that co-pays & payment for non-covered services and goods are payable at the time of each visit or in advance, for mutual convenience. I understand that I am financially responsible for all charges, whether or not paid by insurance, with the exception whereby the negotiated rate for services of my health plan is less than the usual & customary fee schedule of this office.

□* **Traditional Medicare (Part B).** I certify that I, and/or my dependents, have insurance with the above named insurance company. I authorize the use of my signature on all insurance submissions. Medicare regulations dictate that Schantz Chiropractic, P.C. must file my Medicare Part B claims for me, but Medicare does not require us to accept assignment on Part B claims or to file with secondary insurance plans**. I understand that payment for all covered or non-covered services and goods are payable at the time of each visit or in advance, for mutual convenience**. I understand that I am financially responsible for all charges, whether or not paid by insurance.

□ **Private Pay/Cash or Pre-Paid Discount Plan:** I either do not have health insurance that covers chiropractic care or that I exercise my right to not use Health Insurance and not to be bound by its limitations & exclusions. I understand that I am financially responsible for all services at the time they are rendered, unless I enroll in a **Pre-Paid Discount Plan** through this office.

> ***Attention all Medicare Patients*:** Medicare will consider for payment one procedure performed by a Doctor of Chiropractic- Manipulation of the Spine. Although Medicare recognizes that many other services fall under the Chiropractic Scope of Practice, such as examinations for new/established patients, x-rays/MRI, physiotherapies, therapeutic exercise, only spinal manipulation will be considered for reimbursement.

Person responsible for this account: ____

X____Date______________________________

Signature of Patient, Parent or Legal Guardian (if minor)