

# Welcome To Wagner Family Chiropractic, S.C. Adult Intake Form

### Patient Information

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

\_\_\_\_\_

### Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I, the undersigned Certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Wagner Family Chiropractic, SC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
 Responsible Party Signature

\_\_\_\_\_  
 Relationship Date

### Phone Numbers

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

### Accident Information

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

\_\_\_\_\_

### Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

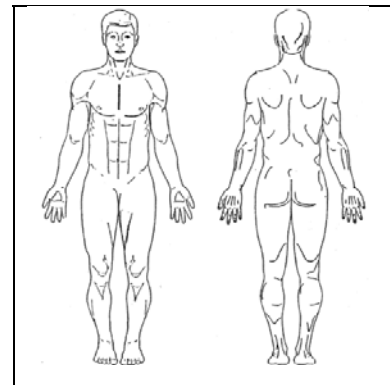
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



## Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_ Spinal Exam \_\_\_\_\_  
 Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_ Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Seen: \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	High <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid <input type="checkbox"/> Yes <input type="checkbox"/> No	Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping <input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

<b>Exercise</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy Type _____	<b>Work Activity</b> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<b>Habits</b> <input type="checkbox"/> Smoking Packs/Week _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____



# Wagner Family Chiropractic, S.C.

N9654 County Road N Ste. #3

Appleton, WI 54915

920-968-0464

[www.wagnerchiropractic.net](http://www.wagnerchiropractic.net)

## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:

- a) A postcard mailed to me at the address provided by me; and
- b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Signature of Individual/Legal Representative\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\*Attorney-In-Fact, Guardian, Parent if a minor\*Attorney-In-Fact, Guardian, Parent if a minor



## **Wagner Family Chiropractic, S.C.**

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### **INFORMED CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT**

Please read each section carefully. You will be furnished with a copy of this form for your own records.

I, \_\_\_\_\_, hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. Although adverse events are extremely rare with chiropractic I understand that with any treatment there are risks. These risks include, but are not limited to fracture, stroke, and even death. I intend this consent to cover the entire course of treatment.

I understand payment is expected at the time of the visit. Any other arrangements, including direct insurance billing, payment plan or deferral, must be made in writing through the front desk. Verbal agreements are not acceptable. Monthly statements will include a 1.5% monthly interest charge on all balances not paid within 30 days.

I realize a notice of 24 hours is encouraged for canceled appointments. I understand that my time slot is only for me and that by missing an appointment without canceling means that someone in need is unable to be seen. Therefore, canceling as early as possible is greatly appreciated to allow others my time slot. (Please call 920-968-0464 to cancel appointments.)

I hereby authorize the release of my medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

\_\_\_\_\_  
Signature of Individual/Legal Representative\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\*Attorney-In-Fact, Guardian, Parent if a minor