New Heights Chiropractic and Rehabilitation, Inc.

Date: _____

Confidential Patient Intake Form

Information contained in this form is considered strictly confidential. Your responses are important to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date of Birth:** _____ **Age:** _____ □ Male □ Female
Address: _____ **City/ State:** _____ **Zip:** _____
Cell Phone: _____ **Home:** _____ **Work:** _____
Email: _____ **Marital Status:** □ S □ M □ D □ W
Height: _____ **Weight:** _____ **What would you prefer to be called in the office?** _____
Social Security #: _____ **Occupation:** _____ **Employer:** _____
Emergency Contact: Name: _____ **Phone:** _____ **Relationship:** _____
How did you hear about us? _____
May we contact you via email regarding appointments? □ Yes □ No **May we send you our online newsletter?** □ Yes □ No

Give a brief, detailed description of the problem you are currently experiencing: _____

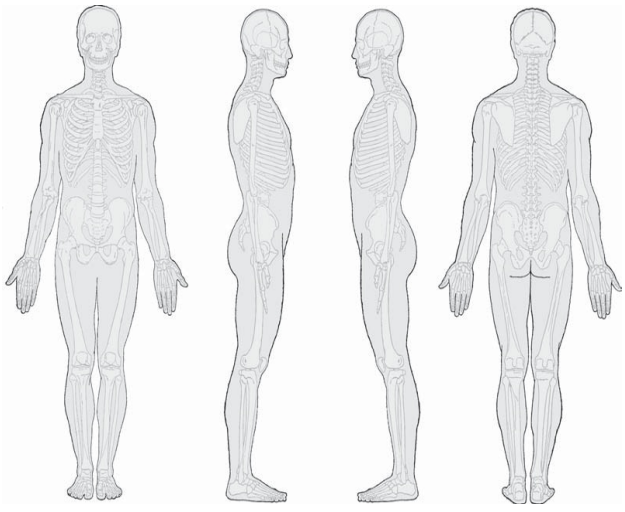
_____

_____

What seemed to be the initial cause? _____
When did this condition begin? _____ **Is this condition:** □ Getting Worse □ Better □ Same
Is this condition interfering with: □ Work □ Sleep □ Daily Routine □ Other: _____
Have you had this or similar conditions in the past? □ Yes □ No, comments: _____
What seems to make this problem better? _____ **worse?** _____

Please indicate your area/s and type/s of pain on the figure below:

Numbness ----------
Pins & Needles oooooooooo
Burning xxxxxxx
Aching *********
Stabbing ////////////



Please place a mark at the level of your pain on the scale below:

No Pain ——————————————— **Worst Possible**

Other doctors or therapists that have treated *this* condition: _____

Name of Current Primary Care Physician: _____ **Date of Last Physical Exam:** _____

May we contact your physician regarding your care at this office? □ Yes □ No

Was this a result of a work related or auto injury? □ Yes □ No, comments: _____

New Heights Chiropractic and Rehabilitation, Inc.

Review of Health History

Name:_____

Please check the corresponding boxes if you have the condition *now* or have had it in the *past*:

General	Now	Past
01. Weakness	□	□
02. Fatigue	□	□
03. Fever	□	□
04. Chills	□	□
05. Night Sweats	□	□
06. Fainting	□	□
Skin		
07. Color Changes	□	□
08. Hair/ Nail Changes	□	□
09. Moles	□	□
10. Rashes	□	□
11. Eczema	□	□
12. Psoriasis	□	□
Head		
13. Headache	□	□
14. Injuries	□	□
15. TMJ Dysfunction	□	□
Eyes		
16. Glasses/ Contact Lenses	□	□
17. Cataracts	□	□
18. Glaucoma	□	□
19. Change in Vision	□	□
Ears		
20. Deafness	□	□
21. Ringing	□	□
22. Ear Ache	□	□
23. Dizziness	□	□
24. Vertigo	□	□
Nose		
25. Decreased Smell	□	□
26. Bleeding	□	□
27. Runny Nose	□	□
28. Sinus Congestion	□	□
Mouth		
29. Bleeding Gums	□	□
30. Sores	□	□
31. Loss of Taste	□	□
32. Dry Mouth	□	□
Throat		
33. Soreness	□	□
34. Hoarseness	□	□
35. Trouble Swallowing	□	□
36. Recurrent Infection	□	□

Neck	Now	Past
37. Stiffness	□	□
38. Soreness	□	□
39. Lumps / Masses	□	□
Cardiovascular		
40. Palpitation	□	□
41. Rapid Pulse	□	□
42. Swollen Ankles	□	□
43. Cold Hands/Feet	□	□
44. Blood Clots	□	□
45. High Blood Pressure	□	□
46. Low Blood Pressure	□	□
Blood		
47. Anemia	□	□
48. Low Iron	□	□
49. Bruise Easily	□	□
50. Bleeding Disorder	□	□
Gastrointestinal		
51. Abdominal Pain	□	□
52. Nausea	□	□
53. Food Intolerance	□	□
54. Heartburn	□	□
55. Indigestion	□	□
56. Constipation	□	□
57. Diarrhea	□	□
58. Hemorrhoids	□	□
59. Bloody/ Black/ Tarry Stool	□	□
60. Diverticulitis	□	□
61. Vomiting	□	□
62. Ulcers	□	□
Genitourinary		
63. Urgency	□	□
64. Incontinence	□	□
65. Frequent Voiding	□	□
66. Blood in Urine	□	□
67. Kidney Stones	□	□
68. Painful Urination	□	□
Respiratory		
69. Chronic Cough	□	□
70. Cough Up Blood	□	□
71. Short of Breath	□	□
72. Wheezing	□	□
73. Difficult Breathing	□	□
74. Chest Pain	□	□

Women Only	Now	Past
75. Lumps in Breast	□	□
76. Hot Flashes	□	□
77. Menopause	□	□
78. Irregular Periods	□	□
79. Birth Control Type:_____		
80. Number of Births:_____		
81. Are You Pregnant? □ yes □ no		
82. Trying To Get Pregnant? □ yes □ no		
83. Date of Last PAP:_____		
□ normal □ abnormal □ not applicable		
84. Date of Last Mammogram:_____		
□ normal □ abnormal □ not applicable		
Men Only		
85. Date of Last Prostate Exam:_____		
□ normal □ abnormal □ not applicable		
Neurological		
86. Seizures	□	□
87. Tremors	□	□
88. Loss of Sensation	□	□
89. Numbness	□	□
90. Tingling	□	□
Endocrine		
91. Weight Loss	□	□
92. Weight Gain	□	□
93. Hyperthyroidism	□	□
94. Hypothyroidism	□	□
Musculoskeletal		
95. Muscle Pain	□	□
96. Muscle Cramps	□	□
97. Muscle Weakness	□	□
98. Joint Stiffness	□	□
99. Arthritis	□	□
100. Low Back Pain	□	□
101. Middle Back Pain	□	□
102. Neck Pain	□	□
103. Upper Extremity Pain	□	□
104. Lower Extremity Pain	□	□
105. Foot Trouble/Pain	□	□
Psychiatric		
106. Depression	□	□
107. Irritability	□	□
108. Anxiety	□	□
109. Nervousness	□	□

Please check the corresponding box if you have had any of the following conditions:

110. □ Measles	116. □ Hypertension	122. □ Asthma	128. □ Appendicitis	134. □ Multiple Sclerosis
111. □ Mumps	117. □ Heart Disease	123. □ Tuberculosis	129. □ Gall Stones	135. □ Syphilis
112. □ Chicken Pox	118. □ Arteriosclerosis	124. □ Pneumonia	130. □ Mental Illness	136. □ Malaria
113. □ Cancer	119. □ High Cholesterol	125. □ Migraine	131. □ Hepatitis	137. □ Gonorrhea
114. □ Tumor	120. □ Stroke	126. □ Gout	132. □ Liver Trouble	138. □ HIV / AIDS
115. □ Angina	121. □ Blood Disease	127. □ Diabetes	133. □ Osteoporosis	139. □ Herpes

New Heights Chiropractic and Rehabilitation, Inc.

Review of Health History (continued)

Name:_____

Please complete the sections below to the best of your knowledge:

List All Previous Surgeries, Traumatic Injuries:

Type	Date	Type	Date	Type	Date
□ None					

List All Medications, Supplements, Herbals:

Name	Dosage	Name	Dosage	Name	Dosage
□ None					

List Any Allergies (Medications, Latex, Food, Chemicals, Inhalants, Etc.)

□ None			

Family History: Please fill in the following information:

Relative	Age (If Living)	Age at Death	Cause of Death	Illnesses
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Social History: Please check the box that most accurately represents you or fill in the blanks:

Sleep: Quality: □ poor □ fair □ good □ excellent
Difficulty falling asleep? □ yes □ no
Frequent waking? □ yes □ no

Exercise:
Days per week: _____
Type/s:_____

Employment:
Describe your job duties:_____
_____

Drug Use:
Do you use illegal or recreational drugs? □ yes □ no

Tobacco Use: Do you smoke or chew tobacco? □ yes □ no
Have you smoked in the past? □ yes □ no
If Yes: Cigarettes:_____ packs/day for ____ years

Diet:
Which best describes your diet? Well-Balanced/ Fast-Food/ Organic/ Paleo/ Vegetarian/ Vegan/ Other: _____

Water: _____ glasses/ounces per day
Coffee: _____ cups per day/week (circle)
Tea: _____ cups per day/week (circle)
Soda: _____ drinks per day/week (circle) regular / diet
Alcohol: _____ drinks per day/week (circle)

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I hereby request and consent to the performance of physical examinations, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and physiotherapy, on myself (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at this office.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to sprains, strains, fractures, disc injuries, dislocation, and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, as I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures along with any therapeutic procedures performed that are within the scope of the treating doctor of chiropractic's license. I intend this consent form to cover the entire course of examination and treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (please print)	Signature of Patient/Legal Guardian
Date	Relationship (if not signed by patient)
Signature of Witness	Date

Kayla Bennett, DC
Daniel Polizzi, DC

Name: _____

New Heights Chiropractic and Rehabilitation, Inc.

Office Financial Policy

New Heights Chiropractic and Rehabilitation wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1) Provide us with accurate and updated information on yourself and your insurance company.
2) Pay at the time of service for your entire balance.

If You Have Health Insurance:
We are happy to file claims for services provided at New Heights Chiropractic and Rehabilitation to your insurance company as a courtesy to you. As stated by your insurance company: **"Verification of benefits is not a guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. **The balance due is your responsibility if we have not received payment from your insurance company within 60 days**.

New Heights Chiropractic and Rehabilitation sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. **Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible, copays and coinsurances must be paid in full.**

By signing this financial policy:

1) You are authorizing New Heights Chiropractic and Rehabilitation, its providers, and its employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment.
2) You are authorizing your insurance company and your medical provider to release your medical records at New Heights Chiropractic and Rehabilitation for the purpose of claim(s) payment.
3) You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to New Heights Chiropractic and Rehabilitation. In the event that your insurance company directly pays benefits to you, the patient, you agree to authorize those payments, in full, to New Heights Chiropractic and Rehabilitation.
4) You are giving New Heights Chiropractic and Rehabilitation the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5) You agree that a photocopy of any document is as valid and effective as the original.

New Heights Chiropractic and Rehabilitation and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. **If Med-Pay is unavailable, it remains the responsibility of the patient to pay for any services rendered at the time of service.**

If you prefer that we do not file insurance claims for you, you may pay cash at time of service and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a superbill, but cannot assist you in filing your claims.

If You Do Not Have Health Insurance:
If you do not have insurance or your insurance company does not cover our services, you will be considered a "self-pay" patient. All payments will be due at time of service/s, or according to the payment schedule based on an authorized payment plan. Payment plans are available to make treatment an affordable part of your budget.

Name:_____

Cancellation Policy:
In order to provide you with the best possible care, please arrive 5 minutes prior to your appointment—late arrival may result in cancellation. **We require 24 hours' notice of cancellation or you will be subject to a $25 fee**. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:
Failure to pay for services and products provided by New Heights Chiropractic and Rehabilitation will result in a finance charge. If we need to forward your account over to a collections agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees.

Payment Options:
For your convenience, we are happy to keep your credit card on file and secured for payment of all services and products.

Non-Sufficient Funds Charges:
We charge a NSF charge if any payment is returned due to insufficient funds. If payment is returned, then we are authorized to charge your credit card on file for the balance owed plus the NSF Charge.

*Signing below also acknowledges receipt of our *Privacy Notice*, which can be provided upon request or accessed online at www.newheightschiroandrehab.com

_____ _____
Responsible Party or Authorized Person Signature Date

_____ _____
New Heights Chiropractic and Rehabilitation Signature Date