

Van Wyk Family Chiropractic Terms of Acceptance

When a patient seeks health care in our office and we accept a patient for such care, it is essential the patient understands the type of services we legally provide.

Chiropractic care is a separate service from the practice of medicine. We do not prescribe drugs or diagnose medical conditions. If we ever feel you have a health situation that may require medical attention, we will advise you to consult with your medical doctor.

I have read and fully understand the above statements. I understand the terms of acceptance and accept care at Van Wyk Family Chiropractic Center on this basis.

(your signature)

(date)

Fees and Financial Policies

Payment will be due at the time services are rendered. If this is a problem, talk with the staff or doctor.

How will you be paying for your chiropractic care?

I will be using health insurance.

Deductibles and/or co-payments will be paid at the time of service or in advance. Your agreement with your health insurance company is between you and them. By signing this financial form, you understand you are responsible for any and all services rendered that your health insurance company denies payment for.

I will be paying without health insurance

Services

Fee

Complete Examination with X-rays and Diagnostic Testing	\$150.00
Chiropractic Adjustment	\$40.00
Medicare Adjustment	\$34.00
Progress Re-Examination	\$40.00
Physical Therapy: Ultrasound & Interferential	\$20.00
Ion Cleanse Detoxification	\$30.00

Products

Fee

Pillows	\$35-\$65
Custom Orthotics	\$75-\$225
Nutritional Supplements	Ask the doctor

I have read and understand the above options and policies. I have checked the method of payment that applies.

(Patient Signature)

(Date)

Practice Member Information

Name _____ Date _____ Age _____ Birthdate ____/____/____
 Address _____ City _____ State _____
 Zip _____ H. Phone () _____ W. Phone () _____
 Email address: _____ Cell Phone () _____
 Social Security Number _____ Occupation _____
 Employer _____ Marital Status S M D W
 Spouses Name _____ Spouses Occupation _____
 Names of Children and ages _____
 Have you ever received chiropractic care? _____ Date of last adjustment? _____
 Whom can we thank for referring you to our office? _____

Current State of Health

Please fill out this section completely. This will help the doctors better understand your current health status.

If you do not have symptoms and are here for wellness care, please skip this section and check the box below.

Wellness Health Care

Main concern or problem _____
 Pain or problem started on _____
 How did the problem occur? _____
 Have you had this problem before? _____ If yes, when was the last time? _____
 What activities aggravate your condition/pain? _____
 What activities relieve your condition/pain? _____

If you have pain, is it: Sharp Dull Burning Tingling Numbness Intermittent Constant

Is the intensity: Mild Moderate Moderately Severe Severe Intolerable

On a scale of 1-10, 10 being the worst, how would you rate your pain when your problem is at its worst? _____

Does pain, numbness, tingling, or burning radiate down your arms or legs? _____

Is the problem worse during certain times of the day? _____

Other doctor(s) seen for this condition? _____ Their recommendations? _____

Is your problem getting progressively worse? (circle one)	Yes	No
Is your problem making you less productive?	Yes	No
Is your problem causing you additional stress?	Yes	No
Is your problem causing a negative attitude or being moody?	Yes	No
Is your problem interfering with your performance at work?	Yes	No
Is your problem interfering with your quality of sleep?	Yes	No
Is your problem affecting your normal routine?	Yes	No
Is your problem affecting your ability to enjoy your hobbies?	Yes	No
Is your problem interfering with your quality of life	Yes	No

Check all the symptoms you currently have, or have had in the last year

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fever | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Buzzing in ears |

Please turn over and complete...

Please list any current medical diagnosis you have or other medical conditions you are experiencing?

Have you had any surgeries or spinal surgeries? Please list the surgery and date.

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Have you had any fractures of the spine or elsewhere? Please list site of fracture and date:

Fracture: _____ Date: _____

Fracture: _____ Date: _____

Fracture: _____ Date: _____

Please list all the current medications you are taking, for what, and the end date of the drug treatment:

Medication: _____ For: _____ End Date: _____

Medication: _____ For: _____ End Date: _____

Medication: _____ For: _____ End Date: _____

Medication: _____ For: _____ End Date: _____

What side effects have you experienced from the drugs?

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I understand that I am ultimately responsible for all fees for services rendered that my insurance company doesn't cover, and that fees are payable within 30 days after discovering what the insurance company will not pay. All other types of payments are to be paid when the services are rendered unless special arrangements are made.

Signature

Date

Quality Of Health Assessment

In our office, we are not only concerned about what brought you in, but also your general health and well being. Give an honest assessment of yourself so that we can provide the best health care and recommendations possible.

Each of the following items can be measured based on your current state of health. Circle the number that best represents your current state of health and well being.

- 0 to 3 a low or poor quality
- 4 to 7 moderate quality, or room for further improvement
- 8 to 10 best quality or most improvement

Circle the number that best represents how you are feeling right now. Circle only one number.

Energy levels	0	1	2	3	4	5	6	7	8	9	10	
Stamina	0	1	2	3	4	5	6	7	8	9	10	
Immunity	0	1	2	3	4	5	6	7	8	9	10	
Quality Of Sleep	0	1	2	3	4	5	6	7	8	9	10	
Dealing With Stress	0	1	2	3	4	5	6	7	8	9	10	
Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	
Joint Flexibility	0	1	2	3	4	5	6	7	8	9	10	
Healthy Digestion	0	1	2	3	4	5	6	7	8	9	10	
Mental Clarity	0	1	2	3	4	5	6	7	8	9	10	
Exercise Activity	0	1	2	3	4	5	6	7	8	9	10	
Positive Attitude	0	1	2	3	4	5	6	7	8	9	10	
Sex Drive	0	1	2	3	4	5	6	7	8	9	10	
Healthy Eating	0	1	2	3	4	5	6	7	8	9	10	
Optimism	0	1	2	3	4	5	6	7	8	9	10	
Quality of Daily Routine		0	1	2	3	4	5	6	7	8	9	10
Ability To Enjoy Hobbies		0	1	2	3	4	5	6	7	8	9	10
General Feelings Of Wellness		0	1	2	3	4	5	6	7	8	9	10