Initial Nutrition Patient Intake Form

Patient Name:_____ **Date:**_____

Address:_____ **City/State/Zip:**_____

Primary Phone: _____ **Secondary Phone:** _____

DOB:_____ **Sex:** Male or Female **SSN#:**_____

Occupation: _____ **Employer:**_____

Primary diagnosis/chief complaint: _____

What is your goal or what are you hoping to achieve from this appointment:

_____

_____

Have you received professional treatment for this condition: YES NO

If yes, with whom: _____

Date of Last Physical Exam: _____

Date of Last Lab Panel: _____

Has this condition affected your sleep quality or your ability to sleep? YES NO

Has this condition affected your appetite? YES NO

List anything that aggravates your condition: _____

_____

List anything that relieves or improves your condition:_____

_____

When did you first notice this condition OR when were you first diagnosed with this condition: _____

_____

Height: _____ **Weight:** _____

Activity Level (check only one) **Blood Type:** A B AB O

- Sedentary (little or no exercise, desk job or bed ridden)
- Lightly Activity (light exercise- sports 1-3 days a week)
- Moderate Activity (moderate exercise- sports 3-5 days a week)
- Very Active (hard exercise- sports 6-7 days a week)
- Extra Active (hard daily exercise- sports and physical job)

Non-Medication Allergies: _____

Current Vitamins, Minerals, Supplements, etc.… _____

_____

Current Medications (name & reason) _____

_____

Medication Allergies : NO YES if yes, please list_____

Surgeries (birth to present)_____

_____

Social History and Life Choices (select the best answer):

Alcohol:
Daily Weekly Occasionally Never

Caffeinated Drinks:
Daily Weekly Occasionally Never

Energy Products/Stimulants:
Daily Weekly Occasionally Never

Drugs:
Daily Weekly Occasionally Never

Fresh/Homemade Foods:
Daily Weekly Occasionally Never

Packaged/Processed Foods:
Daily Weekly Occasionally Never

Restaurant/Takeout Foods:
Daily Weekly Occasionally Never

Tobacco
Daily Weekly Occasionally Never

Water (include how many glasses): _____
Daily Weekly Occasionally Never

For Women Only (only for women over 16 years of age):

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control? YES NO

If yes, is it an oral one? YES NO

Do you have irregular periods? YES NO

Are your periods painful? YES NO

Are you in perimenopause? YES NO

Are you in menopause? YES NO

Do you take hormone replacement therapy? YES NO

Medical History (if multiple choices, please select all that apply):

General: ◯ allergies ◯ fatigue ◯ fainting ◯ anemia ◯ HIV/AIDS ◯ gallbladder problems

◯ weight loss/weight gain ◯ eating disorder ◯ thyroid problems ◯ liver problems

◯ cancer (type)_____ ◯ diabetes (type) _____

◯ rash/Rosacea ◯ eczema/dermatitis/psoriasis/dry skin ◯ acne

Muscle/Joint: ◯ arthritis ◯ rheumatoid arthritis (RA) ◯ neck pain ◯ mid back pain ◯ lower back pain

◯ joint pain (i.e. knee, wrist) _____ ◯ fibromyalgia ◯ gout

◯ scoliosis ◯ osteopenia/osteoporosis

Cardiovascular: ◯ high blood pressure ◯ heart attack ◯ stroke ◯ rapid heartbeat ◯ chest pains

◯ aneurysm ◯ poor circulation ◯ high cholesterol ◯ congestive heart failure

Neurological: ◯ concussion ◯ ADD/ADHD ◯ OCD ◯ seizures ◯ drug/alcohol dependence

◯ arm/hand tingling (which side) _____ ◯ balance problems ◯ loss of smell

◯ loss of taste ◯ foggy brain/poor concentration ◯ headaches/migraines

◯ dizziness ◯ anxiety ◯ depression

GI: ◯ constipation/irregular bowel habits ◯ diarrhea ◯ IBS ◯ Crohn's ◯ Celiac's ◯ ulcer

◯ heartburn/acid reflux ◯ abdominal pain ◯ hemorrhoids ◯ "Leaky Gut" ◯ gas/bloating

Respiratory: ◯ asthma ◯ emphysema ◯ chronic cough ◯ shortness of breath ◯ COPD

Genitourinary: ◯ frequent/painful urination ◯ bladder infection ◯ kidney stones ◯ prostate problems

◯ loss of bladder control ◯ PMS ◯ endometriosis ◯ breast lumps

◯ Profuse/irregular menstrual flow ◯ chronic yeast infections ◯ kidney infection

EENT: ◯ chronic sinusitis ◯ difficulty swallowing ◯ ringing in the ears/tinnitus ◯ vision problems

◯ chronic ear infections ◯ glaucoma ◯ macular degeneration

Any other health concern not listed: _____

**I affirm that the information I have given is correct to the best of my knowledge, and that is my responsibly to inform this office of any changes in my medical status.

_____

Signature Date

INFORMED PATIENT CONSENT

Patient Name: **Account #:**

- My signature below indicates that I understand that if I am accepted as a patient of STEELE CHIROPRACTIC, I am authorizing them to proceed with any further treatment that may be necessary. I understand that there are risks that can be associated with care including stroke, increased nerve sensitivity/numbness, and increased muscle and joint pain. I also understand that any risks involving chiropractic treatment will be explained to me in depth upon request.
  _____ staff initials

_____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

_____

Printed Name and Relationship to Patient

- My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Steele Chiropractic and have read and understood its content.

_____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

_____

Printed Name and Relationship to Patient

BUSINESS/FINANCIAL BILLING ARRANGEMENTS

_____ **NO INSURANCE/PRIVATE PAY:** Payment in full is expected at the time of service.

_____ **COMMERCIAL INSURANCE:** As a service to our patients, Steele Chiropractic accepts assignment of insurance benefits and bills the insurance company for services provided at our office. Insurance is a contract between you and your insurance company. You will be responsible for any deductible, coinsurance and copays. Copays are expected to be paid at the time of service. Failure to present the correct insurance information at the time of your appointment may result in the entire balance becoming your responsibility. This also includes returning requests of information to your insurance company in a timely manner. While we do our best to estimate your insurance benefits, the insurance company makes the final determination on your benefits and coverage. If we are out of network with your insurance company, you are responsible for any portion of the charges not covered by them.

_____**MEDICARE:** We are a participating provider with Medicare and therefore agree to bill and accept assignment from Medicare. Chiropractic manipulations to the spine to improve an injury or health condition are considered medically necessary and are the only service that is covered by Medicare. Medicare does not cover maintenance manipulations, manipulations to an extremity, exams, therapies or supplements and supplies at this office. I understand that if I do not have a supplemental insurance, I will be responsible for all deductible, coinsurance, and non-covered services at this office. If you do have a Medicare supplemental policy, most will cover the Medicare coinsurance. If you have chosen additional Riders on your policy, it may cover deductible services as well. Any supplemental plans written in the state of Wisconsin also follow the Wisconsin State Mandate, meaning many of them will cover maintenance manipulations, manipulations to an extremity, exams, and therapies.

_____**MEDICARE ADVANTAGE PLAN:** We are a participating provider with many Medicare advantage plans, and we accept assignment of benefits for services provided at our office. Most of these plans follow Medicare guidelines, and therefore only cover chiropractic manipulations to the spine to improve an injury or health condition. They normally do not cover maintenance manipulations to the spine, manipulations to an extremity, exams, or therapies. I understand that I will be responsible for all deductible, coinsurance, copays, and non-covered services at this office.

_____**STATE MEDICAL ASSISTANCE/FORWARDHEALTH:** We are a participating provider with Wisconsin State Medical Assistance and agree to bill and accept assignment of benefits for the services provided at our office. Chiropractic manipulations to the spine and exams are the only services covered by Medicaid, and they are limited to 20 visits per condition. Medicaid does not cover maintenance manipulations to the spine, manipulations to an extremity, therapies, or supplements and supplies at this office. I understand that I am responsible for all copays and non-covered services at this office.

_____**WORKERS COMPENSATION/AUTO ACCIDENT:** We agree to bill and accept assignment of benefits from your workers compensation or auto carrier. I understand that opening a claim does not guarantee acceptance of fault nor

does it guarantee payment. It can also take a long time for settlement to be reached in these cases, and some companies will not pay until settlement has been reached. In these circumstances, I understand I may be asked to begin making payments on my account. I also understand that I am responsible for all charges that are denied or non-covered by my insurance carrier.

- PAYMENT is expected at the time of service, unless other arrangements have been made.
- INSURANCE is a contract between the patient and the insurance company and therefore, it is the responsibility of the patient to make sure the account remains current. This includes presenting correct insurance information at the time of service and returning any and all information necessary to the insurance company to get their claims processed. While we will do everything, we can to assist in getting your claims paid and processed, you are ultimately responsible for the services received at this office.
- Patients involved in LITIGATION, WORKERS COMPENSATION, OR AUTO ACCIDENT cases are ultimately responsible for the services received at this office.
- When asking us to bill any insurance, you are acknowledging that the insurance company will pay this office directly for any covered services provided by this office.
- If there is a patient balance, we will send you a monthly statement. Patients are responsible for all charges for services rendered and supplies provided by this office. Payment in full is due within 30 days of receipt of this statement, unless other financial arrangements have been made.

By signing this agreement, I acknowledge that I understand and agree to the policies and terms contained herein.

_____

Patient Signature OR Parent/Guardian/Personal Representative Signature Date

_____

Printed Name/Relationship to Patient

_____

Printed Patient Name and Chart #

Patient Consent for Electronic Reminders

Patients at Steele Chiropractic may be contacted via text messaging to be reminded of an appointment. If at any time I provide a phone number at which I may be contacted, I consent to receive appointment reminders via text from Steele Chiropractic.

_____ (Patient initials) I consent to receive text messages from Steele Chiropractic on my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders is_____.

Steele Chiropractic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Printed Name and Chart #: _____

Parent/Representative Signature: _____Date_____

Patient Signature _____ Date _____

Revocation:

__I hereby revoke my request to receive any future appointment reminders via text messages.
NOTE: This revocation only applies to communications from this Practice.