Whole Healing
Chiropractic & Acupuncture

Dr. Sydney Olson-Griess
Doctor of Chiropractic and DABCA

Whole Healing Chiropractic and Acupuncture

223 E 14th Street, Suite 93
Hastings, NE 68901
Phone: 402-469-2248

Patient Intake Form

Date _____

First Name _____
Last Name _____
DOB _____
Sex ◯ Male ◯ Female
SSN _____
Address _____
City _____
State _____
Zip Code _____

Phone 1 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Phone 2 _____
◯ Home ◯ Mobile ◯ Work ◯ Other
Fax _____
Email _____
Employer _____
Employer Phone _____
Occupation _____

Job Status
◯ Not Employed ◯ Employed
◯ Part-Time Student ◯ Retired
◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ___ ' ___ "
Weight _____ lbs

Reason For Visit: ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury ◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other _____

Referred By: ◯ Provider ◯ Friend ◯ Family ◯ Other _____
Referred By Name _____

How Heard of Us: ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website ◯ Advertisement ◯ Other _____

Demographics

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or Other Specific Islander ◯ Other _____

Ethnicity: ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other _____

Dominance: ◯ Right ◯ Left ◯ Ambidextrous

Insurance Information

Primary Insurance:

Insured First Name _____
Insured Last Name _____
DOB _____
Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____
Co-Ins % _____
Deductible _____ Applied _____
$/Year _____ Visits/Year _____ Therapy Visits/Year _____
PCP Referral Required ◯ Yes ◯ No
Policy Effective Date _____
Cal Yr / Other _____
Other _____

Secondary Insurance:

Insured First Name _____

Insured Last Name _____

DOB _____

Insurance Name _____

Insurance Phone _____

ID # _____ Group # _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Visit Copay _____

Co-Ins % _____

Deductible _____ Applied _____

$/Year _____ Visits/Year _____ Therapy Visits/Year _____

PCP Referral Required ◯ Yes ◯ No

Policy Effective Date _____

Cal Yr / Other _____

Other _____

Emergency Contact Information

First Name _____ Relationship _____

Last Name _____ Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chronic Fatigue	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Asthma	☐ Emphysema	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Epilepsy	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Fibromyalgia	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Chemical Dependency	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Disorder	☐ Venereal Disease
☐ Chicken Pox	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: _____ times per ◯ Day ◯ Week ◯ Month ◯ Year

Duration: Lasting _____ ◯ Minutes ◯ Hours

Onset: Have had symptoms over the past _____ ◯ Days ◯ Weeks ◯ Months ◯ Years

Intensity: ◯ Minimal ◯ Slight ◯ Moderate ◯ Severe

Is your condition: ◯ Same ◯ Better ◯ Worse

Rate your pain: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Aggravating Factors: What makes the problem worse? ☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting ☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning ☐ twisting ☐ walking ☐ working

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching ☐ walking ☐ wraps

What daily activities are affected due to the problem? ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ going from laying down to sitting ☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting ☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: ◯ Good ◯ Insufficient ◯ Erratic

☐ Low (Time of Day) _____ ☐ High (Time of Day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ◯ Yes ◯ No If yes, how much? _____

Daily Habits

Do you smoke? ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ no ◯ light ◯ moderate ◯ heavy

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm ☐ Persistent Coughing

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds

☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply ☐ None

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness

☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling

☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply ☐ None

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary tract infections

☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)

☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst

☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Vascular/Hematologic: Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply ☐ None

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female:

Are you pregnant? ◯ Yes ◯ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Male: Please check all that apply ☐ None

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic 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 authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

_____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date _____

Print Name of Patient, Parent, Guardian or Personal Representative

Whole Healing
Chiropractic & Acupuncture

24 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Whole Healing Chiropractic and Acupuncture, LLC reserves the right to charge a fee of $25.00 for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Shows" in any 12-month period will result in termination from our practice. Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Printed, Last Name, First Date

_____

Signature

PRIVACY STATEMENT FOR PATIENTS

Welcome to our practice. In accordance with the Health Insurance Portability and Accountability Act of 1996, our practice is publishing our privacy and security policies for your reference. Your personal information is protected here at Whole Healing Chiropractic and Acupuncture, LLC. Under the law, your protected personal health information may be released to designated health plans or other health care providers without specific authorization in accordance with the law to treat you, obtain payment and conduct normal practice operations. This is called a CONSENT form. We will ask you to sign our consent form for treatment here at Whole Healing Chiropractic and Acupuncture, LLC. This consent is valid for all treatment and related operational activity. If you wish to release your protected health information for any other purpose, such as a disability, a life insurance company or a physician not associated with your treatment, you will need to sign a specific authorization.

OUR PRIVACY POLICY

1. Whole Healing Chiropractic and Acupuncture, LLC will take all reasonable steps that the minimum necessary amount of information is disclosed to accomplish practice operations, obtain payment for your services and render treatment to you. Such operations include the sending of claims and records to obtain payments, the dictation, typing and filing of medical office notes. Discussion with insurance companies to obtain payment, discussion with collection agencies, i.e., radiologists, laboratory, and other physicians.

2. Your entire medical record will never be released to anyone, unless specifically authorized by you, in writing. You have a right to restrict to whom you allow a portion, or all of your record released to. Your records, may, however be released without an authorization in the course of legal investigations by state or federal agencies. Should you need to restrict to whom your records are released, please call or see the Director of Operations.

3. You have a right to inspect your medical records, with reasonable notice to the Director of Operations. You will then be allowed to inspect the records, with the Director present. You have a right to ask that your medical records be amended, however, that is only a request, and the physician is not obligated to comply. You may address a request to the treating physician. Your request will be evaluated, and a written response sent to you. The request and reply will be kept in your medical record. If you disagree with the decision of the treating physician, you may request that the President of the Practice evaluate the request. His reply shall be sent to you in writing.

4. If you choose to receive a copy of your medical records, the cost of this will be quoted.

5. We keep a list of all medical record releases here at the practice. You have a right to inspect to whom and when your personal health information is sent to.

6. Our staff and physicians are trained in the policies and procedures concerning the release of protected health information. Each of our staff has signed a Confidentiality Agreement here at Whole Healing Chiropractic and Acupuncture, LLC.

7. All complaints regarding the safeguarding of your personal protected health information can be directed to the Director of Operations. You will receive a written reply to any concerns.

8. If there are any changes to this policy statement, it will be posted in our office

PATIENT CONSENT FOR TREATMENT AND RELEASE OF PERSONAL INFORMATION

I have been given a copy of the privacy policy and consent to treatment at Whole Healing Chiropractic and Acupuncture, LLC. I understand that information about me may be used or disclosed in, the context of normal practice operations, including all treatment, filing of claims, and the receiving of payments for services provided. I understand that information for any other purpose may not be released to anyone without my specific authorization. I may revoke this consent at any time, but it will not have any effect on any actions taken prior to my revoking the consent.

Patient Name _____ Date _____

Please Print

Patient Signature _____

If patient unable to sign:

Patient Representative _____ Date _____

Please Print

Patient Representative Signature _____

Relation to Patient _____

I have no objection to the physician discussing my medical or surgical care and treatment with the following persons.

Name: _____ Relationship: _____ Phone: _____

(Please Print)

Name: _____ Relationship: _____ Phone: _____

(Please Print)

Name: _____ Relationship: _____ Phone: _____

(Please Print)

WHOLE HEALING CHIROPRACTIC & ACUPUNCTURE, LLC

FINANCIAL POLICY

We want to thank you for choosing our practice for Chiropractic care. We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our Financial Policy. Please contact the office if you have any questions or concerns.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Whole Healing Chiropractic & Acupuncture accepts cash, cashier's check, VISA, MasterCard, Discover, and American Express. There is a service charge of $25.00 for returned checks. Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments.

***Collections: In the event that your account is forwarded to collections from Northwest Orthopaedics, there will be a 10% charge of your balance for the expenses incurred by the agency. ***

REFUNDS:

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

INSURANCE:

It is the patient's responsibility to provide their current insurance card and or referral at the time of service. If you fail to provide your current insurance/referral information, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payments from your insurance company or if the payments are denied within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Please note your insurance plan determines your co-pay/co-insurance/deductible; they also determine what codes they cover and do not cover. Your EOB (Explanation of Benefits) should outline this information. We do not bill third party insurance companies.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., RPPG, HMO, etc.), you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always guaranteed.

AUTOMOBILE ACCIDENTS/PERSONAL INJURY CLAIMS:

Whole Healing Chiropractic & Acupuncture cannot get involved in third party liability; it is the insurance company's responsibility to determine damages. Patients shall be financially responsible for medical

services related to an MVA and Personal Injury. It is also the patient's responsibility to notify Whole Healing Chiropractic & Acupuncture if the service is due to such incidents.

We will need a claim number, adjustor's name, address, telephone and fax number and/or attorney information for personal injury or workers' compensation.

DISABILITY /FMLA/INSURANCE FORMS:

A $25.00 flat fee, pre-payment will be charged for 3 or more pages. Please allow 7-10 business days for them to be completed.

I have read and understand the Financial Policy of Whole Healing Chiropractic & Acupuncture. I agree to assign insurance benefits to Whole Healing Chiropractic & Acupuncture whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections as mentioned above.

_____ _____

Signature of insured or authorized representative Date