New Patient Intake

Date: ______________ Name: ____ SSN: ______________

How did you hear about us? □ Family/Friend _____________________ □ Facebook □ Google □ Sponsorship □ Other

Date of Birth:_________________ Age: _______ Gender M or F Email: __________________________________

Address: ____City: __________________________ State: _______

Zip: ______________ Phone #: ___________________________ Preferred spoken language: _____________________

Which of the following best describes you: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White or Caucasian □ a race/ethnicity not listed here

Which of the following best describes you: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to state

Occupation: _____________________________________ Employer: ____________________________________

Work Phone: ____________________________________ Spouse Name: _______________________________

Spouse Occupation: ______________________________ Marital Status: ________________ # Children: ____

Emergency Contact: _____________________________ Phone #: _________________Relation: ______________

I consent to chiropractic diagnostic and treatment procedures to be performed by Dr. Jace M. Foss, D.C. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Payment Policies Agreement

I understand that I am responsible for any uncovered charges that the insurance doesn't pay for any reason. If I ask that insurance be billed, I understand and consider reasonable that the office will use the fee schedule and coding for chiropractors as generally determined by the State of Minnesota workers compensation rate; and I hereby assign my insurance company/Medicare or their intermediaries to pay Foss Spine & Wellness health care benefits directly at the business address, to bill insurance for each medical service performed, and assign Dr. Jace to release any administrative or medical information necessary to process insurance claims. I understand there is a $30 charge for returned checks.

Privacy Disclosure (Updated 1/1/2017): This office conforms to the current HIPAA guidelines and policies for health information. A privacy policy is available at the front desk and may be requested if desired. I hereby authorize that my medical records may be forwarded to my other healthcare providers in the best interest of my healthcare or insurance payors in order to process claims information. I understand that Dr. Jace provides regular care in an open, multi-patient treatment area format and that if I have specifically confidential information to share, I will request and be provided private room consultation. I understand that omission of information on this health history, my compliance with care, and providing Dr. Jace and with accurate health condition updates will directly affect the ability of providers at Foss Spine & Wellness to come to proper diagnoses and provide safe and standard care and I agree to hold harmless Dr. Jace for any act of information omission on my part.

I hereby understand and agree to the privacy and payment policies and that the fee schedules are reasonable.

Patient Signature (or guardian) ____ Date: ______________

PATIENT HEALTH HISTORY

Name: ____ **Height:** _______________ **Weight:**_______________

What is your exercise routine? _______________________________________

*** In the next section, you will indicate whether these problems are past or current problems. Circle P if it is a past problem and circle C if it is a current problem. If it does not apply, leave it blank.**

Musculoskeletal & General

P C Degenerative Arthritis
P C Rheumatoid Arthritis or Gout
P C Compression Fracture
P C Osteomyelitis or Spondylitis
P C Osteoporosis
P C Psoriasis or psoriatic Arthritis
P C Fibromyalgia

Musculoskeletal Spine

P C Neck Problem
P C Mid-back Problem
P C Low-back Problem
P C Poor Posture or Scoliosis
P C Disc Injury/Herniation/Bulge

Nervous System

P C Muscle Weakness/Shaking
P C Tingling/Numbness
P C Pinched Nerve/Sciatica
P C Poor Balance
P C Depression
P C Anxiety
P C Dizziness/Vertigo
P C Seizures/Epilepsy
P C Vision Problems
P C Earache or Ear Infections
P C Jaw/TMJ or Mouth Problems
P C Chronic Sinus problems
P C Allergies
P C Sleeping Troubles

Musculoskeletal Extremity

P C Hip or Sacroiliac Issue L R
P C Leg or Knee Issue L R
P C Ankle or Foot L R
P C Shoulder Problem L R
P C Arm/Elbow/Hand Problem L R
P C Rib or Chest Pain

EENT

P C Asthma or Difficulty Breathing
P C Throat or Swallowing Problems

General Systems

P C Diabetes
P C High Blood Pressure
P C Recent Fever over 102 F
P C Thyroid Problem
P C Abdominal Pain
P C Constipation/Diarrhea
P C Heartburn/Acid Reflux/Ulcers
P C Leaky Bladder/Bowel
P C Inflammatory Bowel Disease
P C Menstrual Problems or PMS
P C Menopause Symptoms
P C Pregnancy Problems
P C Pacemaker or Implanted Device
P C History of Stroke or Aneurysm
P C Concerns about Weight

Injuries and General Constitution

P C Car Accident/Whiplash
P C Work or Sports Injury
P C Recent Fall or Accident
P C Smoking Habit
P C Alcohol/Drug Dependence
P C Unexplained Weight Loss
P C Cancer/Tumor
P C Blurred/Double Vision
P C Dizziness, Nausea, or Faintness when neck is moved
P C Medication Issue

Family History (Check all applicable)

- ☐ Chronic Neck/Back Problems
- ☐ Neck or Back Surgery
- ☐ Significant Arthritis
- ☐ Cancer
- ☐ Bone/Joint Problems
- ☐ Frequent Headaches or migraines
- ☐ Stroke
- ☐ Heart Disease
- ☐ None

Please list all medications/vitamins:

____
____
____
____

Please list all surgeries/procedures:

____
____
____
____

REASON FOR VISIT

What is the reason for your visit today? Please write down anything you want the doctor to know: ______________________

____

____

What caused your symptoms? ____ **When?** ______________________

Is this an injury from work or is this a Worker's Compensation claim? Yes No

How often are you feeling your symptoms? (Circle one) Constantly Frequently Occasionally Rarely

Describe your symptoms: (Circle all applicable)

Dull Sharp Throbbing Burning Deep Aching Tingling Stabbing Cramping Numbness Radiating Stiffness

How are your symptoms progressing? Getting worse Not changing Getting Better

Today how severe are the symptoms on a scale of 1-10? (Circle) 1 2 3 4 5 6 7 8 9 10

How much are your work or daily activities affected? Extremely Quite a bit Moderately Little bit None

Have you seen another provider for these symptoms? No Yes, explain: ___________________________________

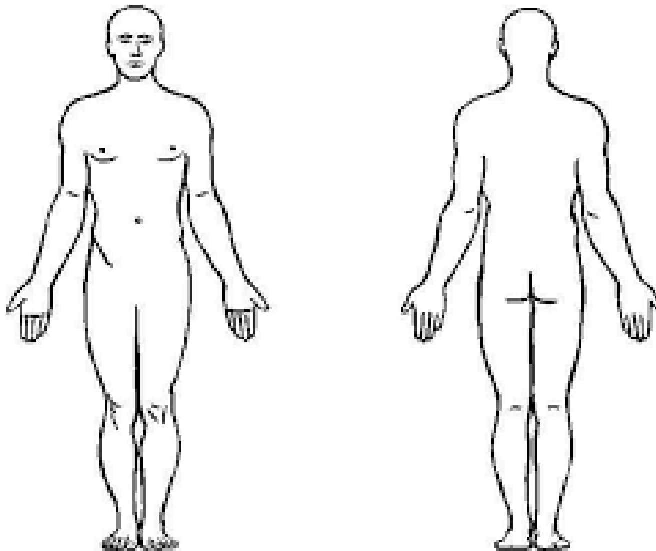
What makes it worse? ___________________________ **What makes it better?** ____________________________________

What concerns you most about this problem? ____

Have you had any MRIs or CT scans taken? Yes No

Name of your Primary Care Physician: ____

Mark your problem areas on the picture:



X-RAY CONSENT FORM

Patient: ____ Date: ________________________

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer your treatment. To perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please choose one:

________ I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

________ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose not to have any x-ray at this time and release my doctor of all liabilities.

Signature: ____ Date: __________________________

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

With those factors in mind, I am advising my doctor that:

I am pregnant	_______ Yes	_______ No	_______ I don't know
I could be pregnant	_______ Yes	_______ No	_______ I don't know
My menstrual period is late	_______ Yes	_______ No	_______ I don't know
I have an IUD	_______ Yes	_______ No	
I have had a tubal ligation	_______ Yes	_______ No	
I have had a hysterectomy	_______ Yes	_______ No	
I have irregular menstrual periods	_______ Yes	_______ No	
My last menstrual period began	________________________		
I have begun menopause	_______ Yes	_______ No	

With full understanding of the above and believing that I am not currently at risk. I wish to have an x-ray examination performed today if requested by my doctor.

Signature: ____ Date: __________________________

Communication Authorization

Please circle yes or no as it applies to the following questions.

May we leave appointment information or messages with the person that answers the phone? Yes or No

May we leave appointment information or messages on your answering machine? Yes or No

May we send appointment information or messages to your email address? Yes or No

May we text appointment reminders/information to your cell phone? Yes or No

Contact

With whom may we discuss your medical condition/billing questions and/or your child's medical condition/billing information/questions than yourself?

If there are no other contacts that you wish to share information with, leave blank and sign.

1.)____________________________ Phone# ________________________

2.)____________________________ Phone# ________________________

Signature ______________________________________ Date_______________