Wisconsin Center for Integrative Health – Tenold Chiropractic Clinic

3814 Oakwood Hills Parkway Eau Claire, WI 54701 *ADULT*

Name____ Date: ________________________________
(First) (Middle initial) (Last)

DOB______________ Age____ Male /Female Home phone_____________________ Cell Phone ___________________________

Marital Status: Single/ Married / Divorced / Widowed Email: ____

Patient's Address ____________________________________City _________________________ State______ Zip_______________

Employer Name: ____Occupation:____

Spouse/Parent/Guardian name____________________________________ Spouse's Employer________________________________

Whom may we thank for referring you? ____

Person to contact in case of an emergency____ Phone__________________________

If the patient is a minor: I give consent to treat. Yes/ No _____________________________________ ___________________
Parent or Guardian signature *Date*

Responsible Party ☐ same as above Is this a Work injury? Yes/No Is this related to an Auto Accident? Yes/No

Person responsible for this account ___________________________________Relationship to Patient: self/ spouse/parent/________

Address ____Home Phone ______________________________

Date of Birth: _________________E-Mail ____Cell Phone ___________________________

Do you have any Medical insurance? Yes / No ☐ Subscriber is the same as the patient / responsible party. (circle one)

Name of the Subscriber____ Relationship to patient: self/spouse/parent/__________

Birthdate___________________ Name of Employer______________________________________ Work Phone _________________

Insurance Company_____________________________________ Group #________________________ ID # ____________________

Ins. Co. Address ______________________________________ City ______________________ State ______ Zip________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Wisconsin Center for Integrative Health and/or Tenold Chiropractic, LLC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this __________ day of ______________________, 20 ____. X____
(Patient signature)

X_________________________________ (signature of Guardian if applicable) X____(print patient name)

Family Medical History…

	Disease	If deceased, cause of death
Mother		
Father		
Sibling(s)		
Child(ren)		
Grandparents		

Indicate which of the below you have experienced in the last 1-2 months

1=Never; **2**=Rarely; **3**=Occasionally; **4**=Frequently; **5**=Constantly

Eyes/Ears/Nose/Throat/Respiratory						**Muscular/Skeletal**					
Asthma	1	2	3	4	5	Muscle aches	1	2	3	4	5
Stuffy nose	1	2	3	4	5	Fibromyalgia	1	2	3	4	5
Hay fever	1	2	3	4	5	Arthritis	1	2	3	4	5
Sore throat	1	2	3	4	5	Joint Pain	1	2	3	4	5
Chronic cough	1	2	3	4	5	Low back pain	1	2	3	4	5
Chest congestion	1	2	3	4	5	Neck pain	1	2	3	4	5
Frequent sneezing	1	2	3	4	5	Wrist/hand pain	1	2	3	4	5
Itchy/watery eyes	1	2	3	4	5	Elbow pain	1	2	3	4	5
Drainage	1	2	3	4	5	Shoulder pain	1	2	3	4	5
Earache or ear infection	1	2	3	4	5	Hip pain	1	2	3	4	5
Itching	1	2	3	4	5	Knee pain	1	2	3	4	5
Hoarseness	1	2	3	4	5	Ankle/foot pain	1	2	3	4	5
Shortness of breath	1	2	3	4	5	Pain between shoulder blades	1	2	3	4	5
Wheezing	1	2	3	4	5						

Neurological						**General**					
Headaches	1	2	3	4	5	Fatigue	1	2	3	4	5
Migraines	1	2	3	4	5	Forgetfulness	1	2	3	4	5
Dizziness	1	2	3	4	5	Weakness, tiredness	1	2	3	4	5
Numbness	1	2	3	4	5	Lightheadedness	1	2	3	4	5
Tingling	1	2	3	4	5	Irritability	1	2	3	4	5
Pins/needles in hands/feet	1	2	3	4	5	Constipation	1	2	3	4	5
	1	2	3	4	5	Diarrhea	1	2	3	4	5
	1	2	3	4	5	Feeling foggy	1	2	3	4	5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ _______   ____ _______

Signature of Patient, Parent or Guardian   **Date**

CLINICIAN SIGNATURE: ____ **DATE REVIEWED:**_____________________

Complaint: ____

Location of pain: ____**Right/Left/Bilateral/Central**

Severity: **0-1-2-3-4-5-6-7-8-9-10** *(No pain)* *(Worst pain)* **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent

Duration: ____________________________________ **Onset**: ____
How long have you had this pain/ problem? When did it start? (What were you doing when this pain/problem began?)

What activities make this worse?____

Complaint: ____

Location of pain: ____**Right/Left/Bilateral/Central**

Severity: **0-1-2-3-4-5-6-7-8-9-10** *(No pain)* *(Worst pain)* **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent

Duration: ____________________________________ **Onset**: ____
How long have you had this pain/ problem? When did it start? (What were you doing when this pain/problem began?)

What activities make this worse?____

Complaint: ____

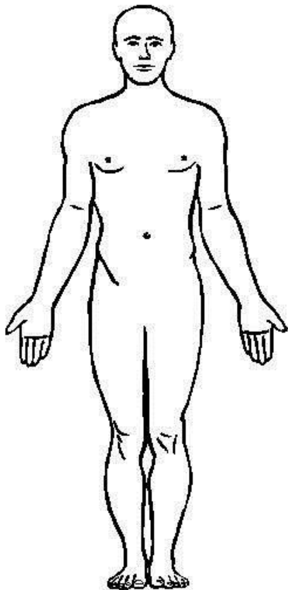
Location of pain: ____**Right/Left/Bilateral/Central**

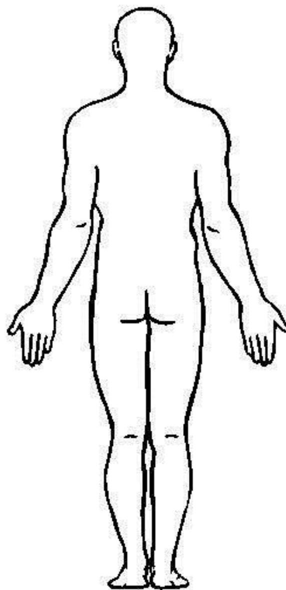
Severity: **0-1-2-3-4-5-6-7-8-9-10** *(No pain)* *(Worst pain)* **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent

Duration: ____________________________________ **Onset**: ____
How long have you had this pain/ problem? When did it start? (What were you doing when this pain/problem began?)

What activities make this worse?____

Mark the appropriate sensation…





Numbness >>>>

Pins & Needles 0000

Burning XXXX

Stabbing ////

Aching ((((

CLINICIAN SIGNATURE: ____ **DATE REVIEWED:**____________________

Past Medical History…

Condition	NO	YES	Condition	NO	YES	Condition	NO	YES	Condition	NO	YES
Measles	NO	YES	Anemia	NO	YES	Back trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Stroke	NO	YES	Fatty liver	NO	YES	Ulcer	NO	YES
Chickenpox	NO	YES	Epilepsy	NO	YES	Hemorrhoids	NO	YES	Kidney disease	NO	YES
Whooping cough	NO	YES	Pneumonia	NO	YES	Venereal disease	NO	YES	Thyroid disease	NO	YES
Scarlet fever	NO	YES	Tuberculosis	NO	YES	Asthma	NO	YES	Polio	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	HIV or AIDS	NO	YES	High cholesterol	NO	YES
Arthritis	NO	YES	Cancer	NO	YES	Bronchitis	NO	YES	Glaucoma	NO	YES
Heart condition	NO	YES	Bladder infection	NO	YES	Infectious Mono	NO	YES	Rheumatic fever	NO	YES
Migraine HA	NO	YES	Hives or eczema	NO	YES	Bleeding tendency	NO	YES	Hernia	NO	YES
Blood or plasma transfusion	NO	YES	High blood pressure	NO	YES	Lyme's disease	NO	YES	Other:		

Previous Hospitalizations/Surgeries/Serious Illnesses (including date)

____

____

Medication: ☐ None. ____

____

(Note what each medication is treating)

Medication Allergies: ☐ None. ____

Vitamins/supplements: ____

Are you currently pregnant? Yes / No If yes, under care of:______________________________________

Surgical Implants: Yes / No Breast implants, hip replacement, knee replacement, pacemaker, spinal stimulator, scoliosis rods, etc.

Patient Social History…

Use of alcohol	/day	/week	Rarely	Never
Use of tobacco	/day	/week	Rarely	Former / Never
Caffeine intake	/day	/week	Rarely	Never
Water intake	oz/day			
Exercise	hours/day	times/week	Rarely	Never
Use of drugs	Daily	Frequently	Rarely	Never

Personal Data…

Race: White / Asian/ African American/ Native American/Other/ Decline

Ethnicity: Hispanic or Latino? Yes/No/Decline

Language(s) spoken: English/ Spanish/ other___________________

CLINICIAN SIGNATURE: ____ **DATE REVIEWED:**______________________