Wisconsin Center for Integrative Health
3814 Oakwood Hills Parkway Eau Claire, WI 54701
(Birth – 5 years old)

Patient Name_____ Date: _____
(First) (Middle Initial) (Last)

DOB_____ Age____ Male /Female Home phone_____ Cell Phone _____

Address _____City _____ State_____ Zip_____

Whom may we thank for referring you? _____

Emergency Contact_____ Phone_____

Responsible Party … Is this related to an Auto Accident? Yes/No

Person responsible for this account _____Relationship to Patient: self/ 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/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		

Pregnancy…Check all that apply to the mother during her pregnancy

alcohol		carried to full term		prenatal care	
allergic reactions		chiropractic care		recreational drugs	
any diagnosed illnesses		complications		smoking	
attitude: mostly depressed		excessive weight gain		toxic exposures	
attitude: mostly happy		excessive weight loss		vaccination(s)	
back pain		hospitalization		vitamins/minerals	
bleeding		medications		physical injury	
caffeine: chocolate, cola		caffeine: coffee, tea		premature contractions	

Labor and Delivery…

greater than 12 hours		epidural		home birth	
complications		vacuum extraction		premature delivery	
fetal monitor		cesarean		medications	

Baby, at birth…

difficulty with breathing		vitamin K drops		nursing problem	
inconsolable crying		circumcision		abnormal skin tone (blue/jaundice)	
medication		erythromycin		other	

Nutrition… check any of the following that the patient has received.

breastmilk		Goat's milk		solid foods	
How long on breast milk?		Other milk (soy, rice, etc.)		vitamins	
commercial formula		Juice: fruit/vegetable		medications	
cow's milk		sweets		other	

Vital Statistics…

The duration of the pregnancy:____weeks. Length at birth:____inches. Weight:____lbs., ___oz.

The APGAR score at birth was_____; at 5 minutes was_____.

Family Physician/Pediatrician…

Name:_____ Clinic Name/Location:_____

Date of last exam & reason for visit:_____

Current Medical History…

Have you chosen to vaccinate the child? Yes / No Note any/all foreign travel: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

Personal Data...

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

Ethnicity: Hispanic or Latino? Yes/No/Decline

All languages spoken: English/ Spanish/ other_____

Consent for Treatment of a Minor Child…

I hereby authorize the doctors/practitioners at Wisconsin Center for Integrative Health and/or Tenold Chiropractic Health Clinic and whomever they designate as their assistant(s) to administer care as they deem necessary to my son / daughter (circle one).

Name of Child: _____

Date at Eau Claire, WI on: _____

Parent or Legal Guardian signature: _____

Witness: _____

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 Parent or Guardian **Date**

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

Health History

Chief Complaint: _____

Body Location: _____ **R/L/B** **Limitations:** _____
(Where is the pain/problem?) *(Right, left, bilateral)* *(Example: not able to golf or not able to sit for ½ hour)*

Severity: **0-1-2-3-4-5-6-7-8-9-10** **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent
(No pain) *(Worst pain)* *(Percent of day that this issue is bothering you.)*

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

Modifying Factors _____
(What activities make this condition worse?)

Associated Signs/Symptoms _____
(What other associated problems have you been having?)

Past Medical History…

Measles	NO	YES	Cancer	NO	YES	Heart condition	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Stroke	NO	YES	Bladder infection	NO	YES	Hives or eczema	NO	YES
Chickenpox	NO	YES	Epilepsy	NO	YES	Rheumatic fever	NO	YES	Kidney disease	NO	YES
Whooping cough	NO	YES	Pneumonia	NO	YES	Hernia	NO	YES	Thyroid disease	NO	YES
Scarlet fever	NO	YES	Bronchitis	NO	YES	Asthma	NO	YES	Lyme's disease	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Blood or plasma transfusion	NO	YES	Bleeding tendency	NO	YES

Previous Hospitalizations/Surgeries/Serious Illnesses (including date)

_____

_____

Medication: ☐ None. _____

_____
(Note what each medication is treating)

Medication Allergies: ☐ None. _____

Vitamins/supplements: _____

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	Never
Caffeine intake	/day	/week	Rarely	Never
Exercise	hours/day	times/week	Rarely	Never
Use of drugs	Daily	Frequently	Rarely	Never

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____