Meinecke Chiropractic & Lifestyle Center
Helping Humans Thrive

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Adult

Wellness Profile

Practice Member Information

File Number _____

Appointment Date: _____

Name: _____ **Male / Female**
Last First M.I.

Prefer to be called: _____ Birth Date: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Type of Work: _____ Work Phone: _____

If workmen's comp… Employer's Address: _____
Street / PO Box City State Zip

Preferred Language: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep. Spouse's Name? _____

Name(s) and Age(s) of Children: _____

In case of an emergency, whom should be notified? _____ Phone _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Payment Information

Person Responsible for Account if Other Than Yourself

Name: _____ Relation: _____

Billing Address: _____
Street City State Zip

Phone: _____ Social Security #: _____ - _____ - _____

Spouse Information

Name: _____ Birth Date: _____

Employer: _____ Work Phone: _____ Social Security #: _____ - _____ - _____

Insurance Information

Primary: _____ Secondary: _____

Member ID: _____ Member ID: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or not covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for services beyond thirty days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process a claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a Photostatic copy of this agreement shall serve as the original.

Patient's Signature: _____ Date: _____

I have read and agree to the above statements.

Wellness Profile

Do you have a specific concern that brings you in?

☐ Yes, _____

☐ No, I'm interested in having my nervous system assessed to achieve optimal health and functioning

If yes, please answer the following questions:

What is your primary area of complaint? _____

How long have you been aware of this? _____ days _____ weeks _____ months _____ years

Where else does this pain go in your body? _____

How often do you experience this? ☐ daily ☐ weekly ☐ monthly ☐ comes and goes ☐ constantly

On a scale of 1 to 10 (10 being the worst), how does it feel at its worst? _____

How would you describe the pain? ☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/stiff ☐ Burning ☐ Sharp

What makes it feel worse? _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? ☐ No ☐ Yes

Do you feel your condition can be healed? ☐ No ☐ Yes

What have you tried that ***has*** helped? ☐ Ice ☐ Heat ☐ Medicine ☐ Massage ☐ Physical Therapy ☐ Chiropractic

What have you tried that ***hasn't*** helped? ☐ Ice ☐ Heat ☐ Medicine ☐ Massage ☐ Physical Therapy ☐ Chiropractic

Have you seen another provider for this condition? ☐ No ☐ Yes, _____

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment of the spinal column as well as damage the delicate nervous system. The result is a condition called a Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Are you happy with your current physical appearance and abilities? ☐ Yes ☐ No

Frequency of exercise/week: Cardio? . . . . . ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Weight bearing? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you stretch after exercise or other activities of poor posture? ☐ Yes ☐ Sometimes ☐ No

Hours of sleep/night? ☐ >6 ☐ 7-9 ☐ 10+

Do you feel refreshed upon waking? ☐ Always ☐ Sometimes ☐ Rarely

Which position do you sleep? ☐ Back ☐ Belly Side: ☐ Right ☐ Left ☐ Both

Hours spent sedentary/day? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6+

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes, why and when? _____

_____

Have you ever been in a motor vehicle accident? ☐ No ☐ Yes, kind and when? _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes _____

Any side effects from drugs / surgeries? ☐ No ☐ Yes _____

Early Years

To your knowledge, was your delivery difficult? ☐ No ☐ Yes

If yes: ☐ Forceps ☐ Vacuum ☐ Caesareans ☐ Breech ☐ Other _____

Were you breast fed? ☐ No ☐ Yes For how long? _____

Did you experience emotional trauma as a child? ☐ No ☐ Yes _____

Were you ever given antibiotics as a child? ☐ No ☐ Yes _____

Did you ever have ear infections as a child? ☐ No ☐ Yes _____

Any major childhood illness? ☐ No ☐ Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Rate your current level of ***relationship stress*** in your life: . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Rate your current level of ***financial stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Rate your current level of ***health stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Rate your current level of ***family stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Rate your current level of ***career stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High

Do you feel you have a supportive network of friends and family? ☐ Yes ☐ No

Do you feel you have healthy coping strategies for life stress? . . . ☐ Yes ☐ No

Chemical

Were you vaccinated as a child? . . . . . ☐ No ☐ Yes

Any adverse reactions to vaccines? . . . . . ☐ No ☐ Yes _____

Do you choose to have annual flu shots? . . . . ☐ No ☐ Yes

Do you take any antibiotics? . . . . . ☐ No ☐ Yes If yes, how often? _____

How many glasses of water/day? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of caffeinated beverages/day? . . . ☐ .0 ☐ 1-4 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of cow's milk, juice and pop/day? ☐ 0 ☐ 1-4 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat gluten? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet

Do you eat dairy? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet

Do you eat refined sugars? (white sugar, white bread, and pasta) ☐ Yes ☐ No ☐ Trying to eliminate from diet

Do you eat boxed/frozen foods? . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet

Do you eat artificial sweeteners? (Splenda, Diet Pop, etc.) . . . . . ☐ Yes ☐ No ☐ Trying to eliminate from diet

Any food/drink allergies, sensitivities, intolerances? ☐ No ☐ Yes _____

Do you drink alcohol? ☐ No ☐ Yes ☐ 0-6/week ☐ 6-12/week ☐ 12+/week

Do you take a probiotic daily? ☐ No ☐ Yes, _____CFU's/day

Do you take vitamin D3 daily? ☐ No ☐ Yes, _____ IU's/day

Do you take Omega 3 Fish Oils daily? ☐ No ☐ Yes, _____mg/day ☐ Capsule ☐ Liquid

Other supplements or homeopathics? _____

Healthcare History

Have you had previous chiropractic care? ☐ No ☐ Yes

Who was your previous chiropractor? _____

Where? _____ When? _____

What was the primary reason for consulting at that office?

☐ Relief Care—Symptom relief of pain or discomfort

☐ Corrective Care—Correcting, relieving, and stabilizing spinal, joint, and postural issues

☐ Wellness Care—Maximizing the body's ability for optimal healing and function

Family Doctor: _____

May we contact your family doctor regarding your care at our office if necessary? No Yes

Other Specialists and Healthcare Professionals:

Name: _____

Professional Designation: _____

Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

☐ Relief care—Symptom relief of pain or discomfort

☐ Corrective Care—Correcting, relieving, and stabilizing spinal, joint, and postural issues

☐ Wellness Care—Maximizing the body's ability for optimal healing and function of the nervous system

Do you have other concerns we should know about? _____

_____

_____

Goals and Consent

What is your primary goal for consulting at our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation:

I _____ hereby grand permission to receive a chiropractic evaluation including history, spinal scan, and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care).

Notice of Privacy

This notice describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please read this carefully.

This office abides by the terms described in this policy.

Meinecke Chiropractic uses and discloses your protected health care information for the following reasons:

- To share with other treated healthcare providers regarding your healthcare
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered
- To determine patient's benefits in a healthcare insurance plan
- Releasing information required by State or Federal Public Health Law
- To assist in overcoming language barriers when caring for a patient
- Business associates providing written assurances for your privacy have been attained
- Emergency times
- Abuse, neglect, or domestic violence
- Appointment reminders to the household or answering machines
- Sign-In sheets may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom
- Speak to our privacy officer who is: Dr. Jason Meinecke and can be reached at: (308) 381-8299 regarding privacy issues
- Inspect copy and amend your protected health information and amend it as allowed by law
- Obtain an accounting of disclosures of your protected health information
- To render a complaint to our privacy officer or to the Secretary of Health and Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the office staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____
Patient's Name (Print) Patient's Signature Date

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New Patient EHR

Intake Form

Name: _____ Date: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian)
☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Date Began Smoking (put n/a if you have never smoked): _____

Are you currently taking any medications? (Please include regularly used over the counter medications) ☐ No ☐ Yes

If yes, please list them here:

Medication Name	***Dosage and Frequency (i.e. 5mg once a day, etc.)***

Do you have any medication allergies? ☐ No ☐ Yes

If yes, please list them here:

Medication Name	***Reaction***	***Onset Date***	***Additional Comments***

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Heart Rate: _____

_____ _____
Patient Signature Date