

WELCOME TO OUR OFFICE

You are the reason we are here! We are committed to earning your trust and confidence by giving you individualized and considerate healthcare. Dr. Knopp and staff always welcome comments and suggestions so that we can learn to serve you better.

*Please arrive on time so we can give you the entire time reserved for you.

*We require twenty-four hours notice to cancel your appointment. It is our policy to charge for no-shows or late cancellations. PLEASE NOTE: Our office will attempt to contact you to reschedule your missed appointment.

*Please respond promptly to the statements mailed to you. You may pay by cash, check or credit card. The fee is \$20.00 for each returned check. Delinquent accounts are transferred to a collection agency.

Health Insurance Plans require you to do the following things:

*Pay your co-payments and deductible to this office.

*Call your insurance company to understand your chiropractic benefits.

*Obtain a physician's referral or authorization if required, before your first visit. If insurance denies payment because the referral or authorization was not in place, you will be responsible for the payment of the fee to this office.

Workplace Injury Claims: In order for a Workers' Compensation claim to be filed by this office, we must verify the case with the employer and the insurance company. You must furnish us the information to do so.

Personal Injury Insurance: In order for our office to file claims to an automobile or homeowner's insurance company, you must furnish us with all the necessary information.

Medicare: This office does not participate with Medicare. We ask you to pay a discounted fee directly to our office and we will file the necessary paperwork to Medicare. You will receive only partial reimbursement of fees from Medicare.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE ABOVE POLICIES

SIGNATURE

Date _____

Anita Knopp DC

CONFIDENTIAL CHIROPRACTIC CASE HISTORY DATE ___/___/___

LAST NAME _____ DATE OF BIRTH ___/___/___

FIRST NAME _____ MIDDLE INITIAL _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ Female ___ Male ___

STREET AND MAILING ADDRESS _____

CITY, TOWN _____ ZIP CODE _____

HOME TELEPHONE NUMBER () _____ - _____ E MAIL _____ @ _____

MAY THIS OFFICE E-MAIL YOU? ___ YES ___ NO

NAME OF EMPLOYER _____

WORK TELEPHONE NUMBER () _____ - _____

MAY THIS OFFICE CALL YOU AT WORK? ___ YES ___ NO

WHO REFERRED YOU TO THIS OFFICE? _____

NAME AND LOCATION OF YOUR GENERAL PHYSICIAN _____

MAY DR. KNOPP SEND A REPORT TO YOUR PHYSICIAN? ___ YES ___ NO

PLEASE CHECK THOSE THAT APPLY TO YOU:

___ I AM SEEKING HEALTH CARE DUE TO A WORKPLACE INJURY
(I HAVE FILED A WC CLAIM)

___ I AM SEEKING HEALTH CARE DUE TO A PERSONAL AUTOMOBILE
INJURY (DATE OF ACCIDENT ___/___/___)

___ I PLAN TO USE MY HEALTH INSURANCE TO PAY MY FEES
(NOTE: NOT ALL PLANS ARE ACCEPTED BY THIS OFFICE)

___ I WILL BE PAYING FEES DIRECTLY TO THIS OFFICE.
(PLEASE SEE THE OFFICE MANAGER FOR INFO REGARDING FEES)

PLEASE FILL OUT THE FOLLOWING PAGES AS THOROUGHLY AS POSSIBLE.

Wellness & Chiropractic Care, LLC, PA, d/b/a Hagerty Chiropractic
298 Maine Street, Brunswick, ME 04011 (207) 729-8656

Anita Knopp DC

THANK YOU FOR THIS VALUABLE INFORMATION.

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Name _____

Date _____

MEDICAL HISTORY

Date of patient's last medical examination? _____ With Dr. _____

Has Patient been hospitalized in the past five years? Y N When? _____

Reason _____

LIST CURRENT MEDICATIONS

CONDITIONS

Arthritis	Polio	AIDS
HIV ARC	Heart Disease	Allergies _____
Tuberculosis	Diabetes	Asthma
Epilepsy	Recent Weight Gain / Loss	Bowel, Bladder, Sexual Dys.
Thyroid Disorder	Rheumatic Fever	Skin Problems
Low / High Blood Pressure	Encephalitis	Digestive Disorder
Ulcer	Cancer	Visual / Hearing Problems
Kidney Stone	Night Sweats	
Dizziness	Heat / Cold Intolerance	Other: _____

FEMALE GENDER:

Hysterectomy: Total / Partial	Mastectomy: Total / Partial
Abnormal Bleeding	Painful Menses
Tubal Ligation	Other _____

Is there a possibility of pregnancy? Y N

How many pregnancies has patient had? _____ # Of Natural Births: ____ # Of Caesarian Section ____

MALE GENDER:

Prostate Disorder Other _____

Name _____

Date _____

INJURY HISTORY

__ Falling Injuries _____	When _____
__ Striking Blow to Head _____	When _____
__ Neck injury _____	When _____
__ Back injury _____	When _____
__ Loss of Consciousness _____	When _____
__ Concussion _____	When _____
__ Car/Motorcycle Accidents _____	When _____
__ Broken Bones _____	When _____
__ Other Physical Trauma/Abuse _____	When _____
__ Military Service _____	When _____

PREVIOUS AND CURRENT TREATMENT

What type of treatment has the patient received for his/her physical problem?

__ Medical _____	When? _____
__ Physical Therapy _____	When? _____
__ Osteopathic _____	When? _____
__ Other _____	When? _____

RESULTS: Better No Change Seems Worse

SELF - TREATMENT

Exercise Over Counter Medications Heating Pad Cold Packs Rest
 Other _____

RESULTS: Better No Change Seems Worse

IMAGING:

__ Spinal X-rays	When? _____	Where? _____
__ CAT SCAN	When? _____	Where? _____
__ MRI	When? _____	Where? _____
__ Other	When? _____	Where? _____

Is patient currently receiving medical or care for another health problem? Y N
 If YES, describe

Anita Knopp DC

Name _____

Date _____

FAMILY HISTORY

Cancer	Thyroid Disease	Diabetes	Heart Disease
	High blood pressure	Stroke	

LIFESTYLE FACTORS

Number of children ____ Caregiver ____
Heavy lifting: Frequent Sometimes Never
Contact Sports: Frequent Sometimes Never
Exercises: Daily 3-5 X/Week 1-2 X/Week Household Chores Outside Chore
Type of Exercises: yoga aerobics jogging walking running weight lifting
 biking skiing swimming team sports golfing tennis/raquetball

Cigarettes: Y N # of packs per day ____
Caffeinated Beverages: Y N How many drinks per day? ____
Alcoholic Beverages: Y N How many times per week? ____

Sleeps an average of ____ hours per night. Fatigued/Fitful Wakes up Often
Position of Sleeping: Back Stomach Side
Mattress Is: New/Firm Old/Saggy Futon Waterbed Other
Pillows Used: 1 2/3 Body Pillow Wedge Under Neck/Head
Relaxes: On Couch In Recliner With Active Hobbies Watches TV in Bed
Other:

OCCUPATIONAL FACTORS

Works: Full Time Part Time Retired
Of Jobs: 1 2 3 Military
Works approximates ____ hours per week.
Works: 1st Shift 2nd Shift 3rd Shift
Commutes ____ hours per day.
Employed by: _____ Self Employed _____
Job Title _____ Years _____ Job Description:

Job Requires: Heavy Lifting Prolonged Sitting/Driving Standing
 Bending/Reaching Heavy Equipment Twisting Body
 Crawling Climbing Mental Fatigue/Strain

The most physically stressful aspect of job is: _____
Is Patient now on limited duty due to a physical problem? Y N
Has there been an ergonomic review and change of workstation? Y N
Previous job was? _____

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AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ____/____/____

Release of Patient Records:

I give my permission to Anita Knopp, D.C. d/b/a Hagerty Chiropractic to release my records to the parties listed below:

Please list **Name** and **Location**

___ Primary Physician _____

___ Other Physician _____

___ Insurance Company _____

___ Attorney _____

___ Other _____

___ Release records directly to me.

SIGNATURE _____ DATE _____

Office Use Only				
Materials Released:	Released To:	Date	Pt. Initial	Returned

NOTE: PLEASE RETURN ALL ORIGINAL X-RAYS TO:

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