WELLNESS & CHIROPRACTIC CARE

Welcome to our practice

PATIENT NAME_____ DOB_____ DATE_____

You are the reason we are here!

We are committed to earning your trust and confidence by giving you individualized and considerate healthcare. Dr. Anita Knopp and staff always welcome comments about your treatment here at our office and suggestions so that we can learn to serve you better.

Who referred you to our office, so that we may thank them? _____

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

* We require 24 hour notice to cancel your appointment.
NOTE: It is our policy to charge for no-shows or late cancellations.

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

Please check below those that apply to you: (A separate form will need to be filled out & signed at time of visit.)

_____Health Insurance: I plan to use my health insurance to pay my fees (Note: not all plans are accepted by this office.) Please bring your current insurance card(s) with you. *Please pay insurance Copays and Deductibles at the time of service.

_____ 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 with the claim information and date of injury 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 claim information and date of accident.

_____ 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.

_____ Self-Pay Patient: I will be paying fees directly to this office at time of visit.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE ABOVE POLICIES

_____ _____

SIGNATURE DATE

Wellness & Chiropractic Care, LLC, PA

298 Maine St., Brunswick, ME 04011 Office: (207) 729-8656 * Fax: (207) 729-7471

www.wellnessandchiropractic.com

WELLNESS & CHIROPRACTIC CARE

CONFIDENTAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Your Last Name _____ **Your Social Security Number** _____ **Birth Date (MM/DD/YYYY)** _____ **AGE** _____

Your First Name _____ **Your Middle Name (or initial)** _____

Gender
◯ Male ◯ Female

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____

Home Phone _____ **Cell Phone** _____

Email Address _____

Emergency Contact _____ **Emergency Contact's Phone** _____

Your Occupation _____

Your Employer _____

Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____

Primary Care Provider's Name _____

Spouse's Name _____

Child's Name and Age _____

Child's Name and Age _____

Child's Name and Age _____

Work Phone _____

May we contact you at work?
◯ Yes ◯ No

Preferred method of contact?
◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Insurance Carrier _____ **Policy Number** _____

Insured's Last Name _____ **Birth Date (MM/DD/YYYY)** _____

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

Insured's First Name _____ **Insured's Middle Name (or initial)** _____

Insured's Employer _____

Address _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____ **Employer's Phone** _____

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New Patient Form

Patient Name_____ DOB_____ Today's date_____

1) What is your chief complaint (1 region)? (i.e. low back) _____
2) When did your symptoms start (provide approx. date)?_____
3) Did your symptoms come on suddenly or gradually?_____
4) Do you know what may have caused your symptoms?(i.e. work, auto, sports)_____
_____

5) How often do you experience your symptoms? (Circle one)

Constantly (76-100% of the day)

Frequently (51-75% of the day)

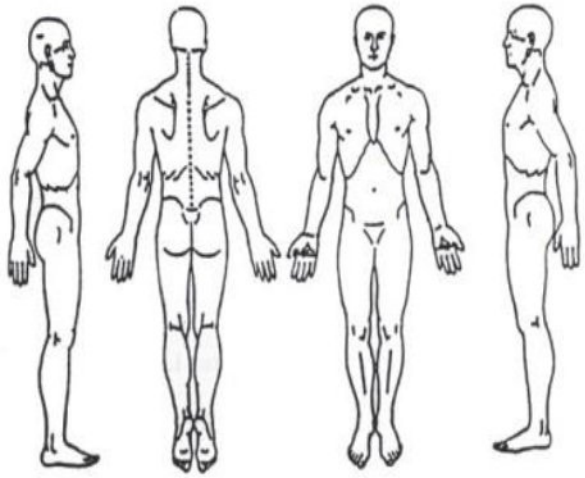
Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

6) Describe the nature of your symptoms:

- o Numbness
- o Tingling
- o Stiffness
- o Dull
- o Aching
- o Cramping
- o Nagging
- o Sharp
- o Burning
- o Shooting
- o Throbbing
- o Stabbing
- o Other_____

7) Circle the area(s) on the illustration to specify where your symptoms are located



7) How bad are your symptoms at their:

	None									Unbearable
Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

8) Do you have any radiating pain? If yes, where? _____

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Pt. Name:_____

9) Aggravating or relieving factors

a) What tends to relieve your symptoms? _____

b) What tends to aggravate your symptoms? _____

10) How have you tried to relieve the symptoms?(i.e. medication, ice, heat, stretches, nothing)_____

11) Review of Systems (Circle 'have' or 'had' if applicable)

a) Musculoskeletal

Had Have **Osteoporosis|** Had Have **Arthritis|** Had Have **Scoliosis|** Had Have **Neck pain|**
Had Have **Back problems|** Had Have **Hip disorders|** Had Have **Knee injuries|** Had Have **Foot/ankle pain|**
Had Have **Shoulder problems|** Had Have **Elbow/wrist pain|** Had Have **TMJ issues|** Had Have **Poor posture|**

b) Neurological

Had Have **Anxiety|** Had Have **Depression|** Had Have **Headache|** Had Have **Dizziness|**
Had Have **Pins and needles|** Had Have **Numbness|**

c) Cardiovascular

Had Have **High blood pressure|** Had Have **Low blood pressure|** Had Have **High cholesterol|**
Had Have **Poor circulation|** Had Have **Chest pain|** Had Have **Excessive bruising|**

d) Respiratory

Had Have **Asthma|** Had Have **Apnea|** Had Have **Emphysema|** Had Have **Hay Fever|**
Had Have **Shortness of breath|** Had Have **Pneumonia|**

e) Digestive

Had Have **Anorexia/bulimia|** Had Have **Ulcer|** Had Have **Food sensitivities|** Had Have **Heartburn|**
Had Have **Constipation|** Had Have **Diarrhea|**

f) Sensory

Had Have **Blurred vision|** Had Have **Ringing in ears|** Had Have **Hearing loss|**
Had Have **Chronic ear infections|** Had Have **Loss of smell|** Had Have **Loss of Taste|**

g) Skin

Had Have **Skin cancer|** Had Have **Psoriasis|** Had Have **Eczema|** Had Have **Acne|** Had Have **Hair loss|**
Had Have **Rash|**

h) Endocrine

Had Have **Thyroid issues|** Had Have **Immune disorders|** Had Have **Hypoglycemia|**
Had Have **Frequent infection|** Had Have **Swollen glands|** Had Have **Low Energy|** Had Have **PMS symptoms|**

i) Genitourinary

Had Have **Kidney stones|** Had Have **Infertility|** Had Have **Bedwetting|** Had Have **Prostate issues|**
Had Have **Erectile dysfunction|**

j) Constitutional

Had Have **Fainting|** Had Have **Low libido|** Had Have **Poor appetite|** Had Have **Fatigue|**
Had Have **Sudden weight gain|** Had Have **Sudden weight loss|** Had Have **Weakness|**

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Pt.Name:_____

12) Illnesses (Circle 'Had' or "Have")

Had	Have	HIV/AIDS	Had	Have	Glaucoma
Had	Have	Alcoholism	Had	Have	Goiter
Had	Have	Allergies	Had	Have	Gout
Had	Have	Arteriosclerosis	Had	Have	Heart Disease
Had	Have	Cancer	Had	Have	Hepatitis
Had	Have	Chicken Pox	Had	Have	Malaria
Had	Have	Diabetes	Had	Have	Measles/Mumps
Had	Have	Epilepsy	Had	Have	Multiple Sclerosis
Had	Have	Polio	Had	Have	Rheumatic Fever
Had	Have	Scarlet Fever	Had	Have	Sexually Transmitted Disease
Had	Have	Stroke			

13) List all surgeries/operations (laterality with month/year):

_____ _____ _____ _____

_____ _____ _____ _____

14) List all injuries (Concussions, fractured/broken bones, accidents) include laterality with month/year

_____ _____ _____ _____

_____ _____ _____ _____

15) Social History

Alcohol use	◯Daily ◯ Weekly - How much?_____
Coffee use	◯Daily ◯ Weekly - How much?_____
Tobacco use	◯Daily ◯ Weekly - How much?_____
Exercising	◯Daily ◯ Weekly - How much?_____
Pain relievers	◯Daily ◯ Weekly - How much?_____
Soft drinks	◯Daily ◯ Weekly - How much?_____
Water intake	◯Daily ◯ Weekly - How much?_____
Hobbies	◯Daily ◯ Weekly - How much?_____

16) Has this current condition interfered with work/career?_____

17) What is the major stressor in your life?_____

18) How many hours do you sleep on average per night?_____

19) What is the approximate age of your mattress? _____ **Pillow?** _____

20) What is your preferred sleeping position?_____

21) Daily eating habits: ◯ Skip breakfast ◯2 meals ◯3 meals ◯snacking between meals

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Pt.Name:_____

22) What would be the most significant thing you could do to improve your health?

_____

23) Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No	mild	moderate	severe
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No	mild	moderate	severe
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering/bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love Life	◯	◯	◯	◯
Getting asleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentration	◯	◯	◯	◯
Exercises	◯	◯	◯	◯
Yardwork	◯	◯	◯	◯

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Patient signature_____ Date_____

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For your first visit:

- Wear active clothing without metal, such as yoga or sweat pants.
- Bring medication and allergy lists if applicable
- Bring PCP contact information

For every visit:

- Please remove coats, sweatshirts, turtlenecks, scarfs, and other extra layers prior to all treatments.
- Please remove jewelry
- If you have long hair please tie up without metal accessories.
- Please remove your shoes when you enter the office; to help reduce environmental toxins in the building
- Bring insurance card(s)

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Cancellation Policy

Here at Wellness and Chiropractic Care we understand that there are interruptions to your daily life, such as; illness, car problems, traffic delays, work issues, etc. These interruptions may be a reason to cancel your appointment.

Our commitment is to provide a quality chiropractic experience for all of our patients. Out of consideration for other patients, staff and the Doctor's time we are adopting the following policies:

Arrival to our practice

Please arrive 10 minutes prior to your scheduled appointment, this allows time for questions, to complete any necessary forms and preparation for you appointment (remove layers of clothing, jewelry, shoes etc.).

All services offered have a specific time schedule and early arrival allows for an enjoyable and relaxed experience. If a late arrival is inevitable, your appointment may be rescheduled in order to keep on schedule for other patients.

Cancellation Policy

We have a 24 hour cancellation policy. Full credit will be given if the appointment is cancelled or rescheduled 24 hours prior to the scheduled appointment time. No refund will be given for less than a 24 hour cancellation notice. Consideration offered for emergencies or unforeseen events.

Late Arrival Policy

As a courtesy to other patients and staff, appointments will be automatically cancelled 15 minutes after scheduled start time and charged according to our cancellation policy. We cannot guarantee that late arrivals will receive an extension of their scheduled appointment. In special cases and when our schedule will allow, we may be able to accommodate another appointment, this will be at our discretion and only with proper advanced notification of your late arrival.

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Informed Consent for Chiropractic Treatment

Name: _____DOB: _____

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulation treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and or other assistants and or licensed practitioners.

I understand, as with any health care procedures that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some type of manipulation of the neck have been associated with injures to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctors feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risk of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read or have had read to me the above explanation of chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to the treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient signature or patient representative Date

Witness to patient signature or patient representative Date

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Informed Consent for
Kinesio Taping and Laser Treatments

Patients Name: _____ DOB: _____
Please Print

____ Kinesio Taping is a rehabilitative taping technique that is designed to facilitate the body's natural healing process while providing support and stability to muscles and joints without restricting the body's range of motion as well as providing extended soft tissue manipulation to prolong the benefits of manual therapy administered within the clinical setting. Latex free and wearable for days at a time, Kinesio Tex Tape is safe for populations ranging from pediatric to geriatric. Kinesio Tex Tape alleviates pain and facilitates lymphatic drainage by microscopically lifting the skin. This lifting affect forms folds in the skin thus increasing the interstitial space and allowing for decrease in inflammation of the affected areas. Please ask your doctor about the benefits of Kinesio Taping and its effect on your treatments.

Kinesio Taping is a non-billable service for insurance purposes. We offer it for a discounted rate payable at the time of service.

By signing this form you are agreeing to the service to be provided and the cost associated with it, should the doctor decide it is an appropriate part of your treatment plan.

____Laser Treatment Erchonia Lasers emit visible coherent light that is applied to affected areas. Bundles of light energy pass through the dermal layers, and are received within the cell membrane by specific energy photo acceptors. The increase in intra-cellular energy results in altered cell membrane permeability and physiological changes occur through an enzyme cascade to affect several biological processes. Within the injured musculoskeletal tissue, low-level laser light initiates increased microcirculation and enhanced tissue regeneration. The overall effects are decreased pain and inflammation, and increased range of motion.

Laser treatment is a non-billable service for insurance purposes. We offer it for a discounted rate payable at the time of service.

By signing this form you are agreeing to the service to be provided and the cost associated with it, should the doctor decide it is an appropriate part of your treatment plan.

_____

Patient signature or patient representative Date

_____

Witness to patient signature or patient representative Date

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Low Back Oswestry

(These questions are specific to your back pain)

Section 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and it moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4 .
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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Neck Index Oswestry

Section 1 – Pain Intensity
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading
- ❑ I can read as much as I want to with no pain in my neck. I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – Headaches
- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration
- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – Work
- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

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