N E R E M

FAMILY CHIROPRACTIC INC.

925 S.E. Gateway Dr., P.O. Box 547, Grimes, Iowa 50111, 515-986-1400 / Fax 515-986-7111

Personal Information: Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Last First Middle

Address Apt.

City State Zip

( ) ( ) ( )
Home Number Cell Number Work Number E-mail Address

If you would like a **text reminder** of future appointments, please provide the name of your cell provider (ie, Verizon, US Cellular). The text will not go through unless we have the name of the carrier: _______________________________________
How soon before your appointment would you like the reminder sent? ___________________________
If you would like an **email reminder** of future appointments, how soon before your appointment would you like the reminder sent? ____

Employer Name Occupation Title

( ) ( ) ( )
Emergency Contact Name/**Relationship** Home Number Cell Number Work Number

Current Health Condition: What brought you to our office today?

Unwanted Condition: _______________________________________

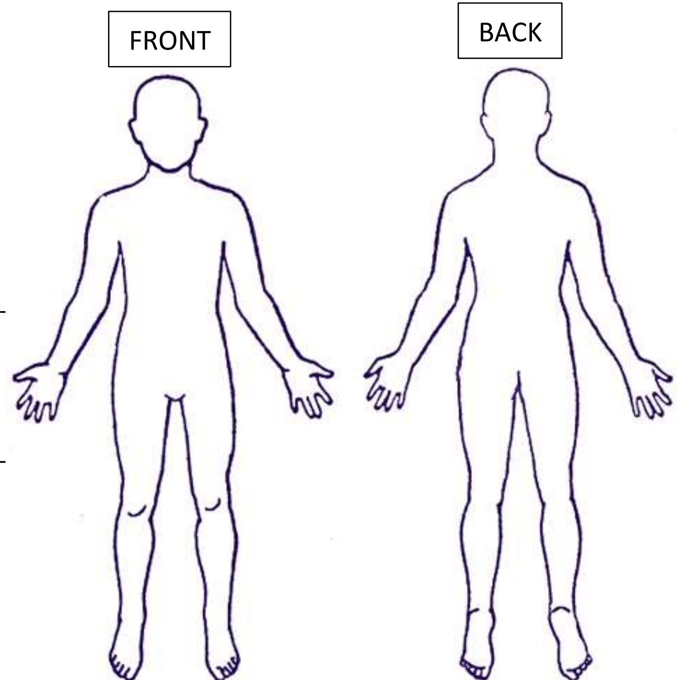
Please indicate the location of the sensations you are experiencing.

When did this condition/pain BEGIN?: _____/_____/_____

Has it ever occurred before? ___Y___N When: _____/_____/_____

Is this condition: ___ Auto related ___ Job Related
___ Home Injury___ Slip / Fall ___ Lifting ___ Slept Wrong
___ Unknown ___ Other – Please explain ________________________
____

Date of Accident: _____/_____/_____
Time of Accident _____ a.m./p.m.



Do you suffer from ANY OTHER CONDITION (ie, diabetes) than which you are now consulting us? Please explain __________________________________

Previous care for the current condition we are seeing you for:

___ No, I have not previously seen a doctor for this condition, OR

___ Yes, I have previously seen a doctor for this condition and his/her information is below:

Other doctors seen for this condition: ___ Chiropractor ___ Medical ___ Other ____________________

Type of Treatment: ____

Were you satisfied with the results of the treatment? ___ Yes ___ No

Please explain:____

____

Review of Systems: Please check all CURRENT and PAST conditions. List any health conditions that are not shown below. Even if a condition seems unrelated to care, please check. These may affect your overall health.

	ADD		Cystic kidney disease		High / low blood pressure		Psychiatric problems
	Alzheimers		Depression		Influenza pneumonia		Scoliosis
	Anemia		Diabetes (insulin dep)		Liver disease		Seizures
	Arthritis		Diabetes (non-insulin)		Lung disease		Shingles
	Asthma		Eczema		Lupus erythema (discoid)		Past history of similar symptoms
	Cancer		Emphysema		Lupus erythema (systemic)		STD'S (unspecified)
	Cerebral palsy		Eye problems		Multiple sclerosis		Suicide attempt(s)
	Chicken pox		Fibromyalgia		Parkinson's disease		Thyroid problems
	Crohn's / colitis		Heart disease		Unspecified pleural effusion		Dizziness
	CRPS (RSD)		Hepatitis		Pneumonia		Diarrhea/constipation
	CVA (stroke)		HIV		Psoriasis		High cholesterol
	Anxiety / stress		Heartburn		Difficulty sleeping		Frequent colds
	Jaw pain		Numbness		Fatigue		Other:
	Sinus problems		Headaches		Currently pregnant		Other:
	Ear infections		Traumatic birth (your own)				

Surgery (ies): List ALL surgical procedures. Write the DATE of the procedure immediately afterward.

	Angioplasty		Cosmetic		Hysterectomy		Pacemaker insertion
	Appendectomy		D & C		Joint reconstruction		Rotator cuff
	Caesarian section		Dental surgery		Joint replacement		Spinal fusion
	Cardiac catheterization		Gall bladder		Knee repair		Tonsillectomy
	Carpal tunnel repair		Hemorrhoidectomy		Laminectomy		Other:
	Coronary artery bypass		Hernia repair		Mastectomy		Other:

Injury(ies): Mark or list ALL injuries: Write the DATE of the injury immediately afterward.

	Back injury		Head injury (loss of consciousness)		Motor vehicle accident
	Broken bones		Head injury (no loss of consciousness)		Soft tissue injury (mild)
	Disability (ies)		Industrial accident		Soft tissue injury (severe)
	Fall (severe)		Joint injury		Other:
	Fracture		Laceration (severe)		Other:

Family History:

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them?

____

Social History: Mark all that apply below:

Alcohol: ___ None ___ Social consumption only ___ Drink regularly, quantity of ___ glasses per___

My dietary intake consists mainly of the following: (mark all that apply)

	High Fat		High Salt		Low Fiber		Low Sugar
	Low Salt		High Fiber		Low Carbohydrate		

Tobacco:

___ None ___ Live with a smoker ___ Quit Smoking ___ Smoke/Chew

Goals for my care: (Please read the following thoroughly so you know why these forms are important.)

At Nerem Family Chiropractic we focus on your ability to be healthy. Our goals are to first address the *issues* that brought you to this office, and second, to offer you the opportunity to improved health, wellness and quality of life in the future.

On a daily basis we all experience physical, biochemical and psychological / emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the questions on these forms gives us a profile of your specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

In addition, we would like to know what your goals here are. Please check one or more of the following:

___ **Relief Care** -- Treatment designed to address an obvious symptom, disease, or condition.

___ **Stabilization Care** – Continue with the care necessary to fully heal soft tissues and muscles.

___ **Wellness Care** -- Non-symptomatic or maintenance care, designed to maximize optimum spinal and nervous system function and help prevent disease.

Are we coordinating care with your physician?

I would like a copy of my records sent to my physician ___ Yes ___ No

(Please indicate) Primary Care Physician, Ob/Gyn, Asthmatic Specialist, Orthopedic Surgeon, Internist,

Other Doctor: ____________________

Clinic's Name and Address:

____

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Nerem and /or other licensed doctors of chiropractic who now or in the future work at Nerem Family Chiropractic, Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.   I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information. I assume and agree to be held responsible for reasonable collection agency fees, "administration fees", filing fees, court costs and other costs incurred if my account enters default status.

Patient Print Name: __________________________ Patient's Signature: __________________________________ Date: _____/_____/_____

Consent to Treat a Minor / Guardian or Spouse's Signature of Authorizing Care:

Parent / Guardian Print Name: _______________________________________   Date: _____/_____/_____

Parent / Guardian's Signature: _______________________________________

ASSIGNMENT OF INSURANCE BENEFITS FORM

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO NEREM FAMILY CHIROPRACTIC, INC., FOR ANY SERVICES FURNISHED ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier* as *the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.*

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Print Name ________________________________

Signature _________________________________Date ________________

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:__________________________ **Last Name**:__________________________

Email address: _________________@_________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female

Preferred Language:___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

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

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications/**no** vitamins, herbals, etc. please.)

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

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **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.)*

Patient Signature: ____Date:_________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______