Dr. Marie-Andrée Gélinas, D.C.
560 Centennial Center Blvd, Suite 150
Hobart, WI 54155
920.865.7225

Name____

Address____________________________________City________________State________

Zip____________

Gender: ❑ M ❑ F   Birth date_____/_____/_____Age______ Social Sec. #: ___________________________

Home Phone #__________________ Cell Phone #: _____________________Work Phone #: _________________

Email Address:____ Preferred Contact Method:_______________

How did you hear about our office? ____

Employment Status: ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Place of Employment: ____ Occupation: ___________________

Marital Status: M   S   D   W   Spouse's Name: ____

Children's Names and Ages: ____

Emergency Contact: ____________________________ Relation: ___________________ Phone #: ____________

Major complaints and symptoms *(Please be as specific as you can)*

Unwanted Conditions (Why are you here today?) ____

When did the Condition BEGIN? _____/_____/_______ Has it ever occurred before? ❑No ❑Yes, When? ____

Is this condition: ❑Auto Related ❑Job Related ❑ Home Injury ❑Slip or Fall ❑ Lifting ❑Slept Wrong

❑Unknown cause ❑Other:____

Have you had chiropractic care before? ❑No ❑Yes, Date of last treatment? _____________________________

What was the reason/complaint for your treatment at that time? ____

Social History

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

  If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Do you currently drink alcohol of any kind? ❑ Yes ❑ Former drinking ❑ Never been a drinker

  If yes, how often do you drink? ❑ Current every day drinker ❑ Current sometimes drinker

Do you exercise regularly? ❑Yes ❑No

Review of Systems:

Below is a list of symptoms that may seem unrelated to the purpose of your visit today, however, these questions must be answered carefully as the problem can affect your overall health. Please check any symptoms you **currently** experience.

Constitutional:

❑chills ❑fatigue ❑night sweats ❑weight loss ❑daytime drowsiness ❑Fever ❑weight gain

❑I do not have any of these symptoms

Eyes/Vision:
❑blindness ❑change in vision ❑field cuts ❑photophobia ❑blurred vision ❑double vision ❑glaucoma
❑tearing ❑cataracts ❑eye pain ❑itching ❑wear glasses/contacts ❑I do not have any of these symptoms

Ear, Nose and Throat:
❑ear drainage ❑hearing loss ❑nosebleeds ❑dentures ❑ear pain ❑ringing in the ear
❑postnasal drip ❑runny nose ❑TMJ ❑loss of smell ❑sinus infection ❑dizziness ❑headaches
❑nasal congestion ❑snoring ❑difficulty swallowing ❑sore throat ❑hoarseness
❑I do not have any of these symptoms

Gastrointestinal:
❑abdominal pain ❑diarrhea ❑constipation ❑abnormal stool consistency ❑abnormal stool color ❑hemorrhoids
❑rectal bleeding ❑indigestion ❑vomiting ❑vomiting blood ❑belching ❑difficulty swallowing
❑I do not have any of these symptoms

Respiration:
❑asthma ❑chest pain ❑cough ❑coughing up blood ❑sputum production ❑shortness of breath ❑wheezing
❑I do not have any of these symptoms

Cardiovascular:
❑chest pain ❑high blood pressure ❑shortness of breath with exercise ❑low blood pressure ❑fainting
❑swelling in legs ❑leg pain/aches ❑Difficulty breathing while laying down ❑ulcers ❑heart murmur
❑palpitations ❑varicose veins ❑heart problems ❑I do not have any of these symptoms

Female:
❑birth control ❑cramps ❑irregular period ❑Vaginal discharge ❑vaginal bleeding ❑breast lumps/pain
❑frequent urination ❑burning urination ❑hormone therapy ❑urine retention
❑painful intercourse ❑I do not have any of these symptoms
Date of last menstrual period ________________
Do you have any reason to believe that you may be pregnant? ❑Yes ❑No

Male:
❑frequent urination ❑burning urination ❑prostate problems ❑painful intercourse ❑erectile dysfunction
❑dribbling ❑urine retention ❑I do not have any of these symptoms

Endocrine:
❑cold intolerance ❑heat intolerance ❑excessive hunger ❑excessive thirst ❑goiter ❑unusual hair growth
❑hair loss ❑diabetes ❑voice changes ❑I do not have any of these symptoms

Skin:
❑change in nail texture ❑change in skin color ❑hair loss ❑hives ❑history of skin disorder ❑rash
❑paresthesias ❑varicosities ❑skin lesions/ulcers ❑I do not have any of these symptoms

Nervous System:
❑Dizziness ❑limb weakness ❑numbness ❑slurred speech ❑tremor ❑facial weakness ❑loss of consciousness
❑seizures ❑stress ❑ loss of balance ❑headaches ❑loss of memory ❑stroke ❑sleep disturbance
❑I do not have any of these symptoms

Psychological:
❑anxiety ❑behavioral change ❑convulsions ❑memory loss ❑loss of appetite ❑bi-polar disorder
❑depression ❑mood changes ❑confusion ❑insomnia ❑I do not have any of these symptoms

Hematologic:
❑anemia ❑blood clotting ❑bruising easily ❑lymph node swelling ❑bleeding ❑blood transfusion
❑fatigue ❑I do not have any of these symptoms

Known allergies: ____

Current Medications: *List ANY/ALL medications you are CURRENTLY taking. Be Specific*

Medication	*Dosage*	*Reason*	*How long have you been taking this?*

Current Vitamins, Herbs, etc.: *List ANY/ALL non-prescription you are CURRENTLY taking. Be Specific*

Supplement	*Dosage*	*Reason*	*How long have you been taking this?*

Surgery (ies):

Mark or list all surgical procedures. **Write the DATE of the procedure immediately afterward**.

❑angioplasty
❑coronary artery bypass
❑pacemaker insertion
❑gall bladder
❑appendectomy
❑hernia repair
❑caesarian section
❑hysterectomy
❑cardiac catheterization
❑joint reconstruction
❑knee repair
❑joint replacement
❑carpal tunnel repair
❑cosmetic
❑mastectomy
❑dental surgery
❑rotator cuff
❑spinal fusion
❑tonsillectomy
❑Other__________________
____

Injury (ies):

Mark or list all injuries. **Write the DATE of the injury immediately afterward**.

❑back injury
❑joint injury
❑broken bones
❑laceration (severe)
❑disability
❑motor vehicle accident
❑fall (severe)
❑soft tissue injury(moderate)
❑soft tissue injury (severe)
❑fracture
❑head Injury
❑loss of consciousness
❑industrial Accident
❑other:__________________
____

Family/Personal Health History

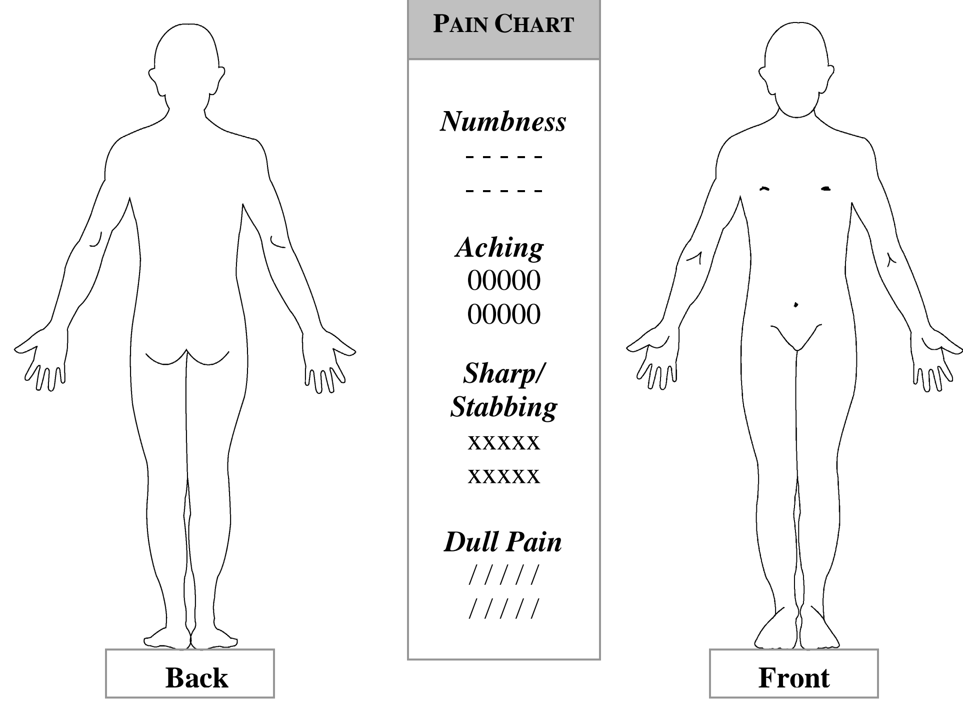
Check "Yes" if you are adopted and your family history is ***unknown***: ❑ Yes

Indicate if ***you*** or any of your ***close relative*** (parents, grandparents, brother, sister, child) has had the following diseases:

Diabetes ❑ Yes ❑ No, Who ____
Heart trouble ❑ Yes ❑ No, Who ____
Stroke ❑ Yes ❑ No, Who ____
Cancer ❑ Yes ❑ No, Who ____
❑Other: ________________________, Who __________________________________
❑Other: ________________________, Who
____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations by using the appropriate symbols from the Pain Chart. Mark areas of the body if the pain travels (i.e. Legs or arms).



Mark on the following pain scale the pain you feel with this condition. (From Zero to 10):

Neck-Shoulder-Arm Pain	**Mid Back Pain**	**Low Back Pain-Leg Pain**
0 1 2 3 4 5 6 7 8 9 10	**0 1 2 3 4 5 6 7 8 9 10**	**0 1 2 3 4 5 6 7 8 9 10**
no pain **severe pain**	**no pain** **severe pain**	**no pain** **severe pain**

PLEASE READ AND SIGN BELOW

The information above is true and accurate to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Furthermore, I understand that Healthy Living Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to Healthy Living Chiropractic will be credited to my account upon receipt. I am aware that my exam, x-rays and adjustments may be recorded to enhance record keeping. I clearly understand and agree that I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

____ ____________________

Patient/Guardian Signature **Date**

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I ________________________________ do hereby give my consent to the examination and diagnosis testing deemed necessary and to the performance of conservative noninvasive treatment to the joints and soft tissues.

I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to one in ten million treatments. Once in a million is about the same as getting hit by lightning. Once in ten million is about the same chance as a normal does of aspirin or Tylenol causing death.

Tests will be performed on me to minimize risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

I understand that there are other alternatives to chiropractic such as; rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

I have read or have had read to me the above explanation of chiropractic procedures. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for examination, diagnosis testing and treatment.

________________________________ ____________ ________________________________
Signature of patient Date Doctor's Signature

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PROTECTING YOUR HEALTH INFORMATION

New Regulations Passed
The new regulations are part of the Health Insurance Portability and Accountability Act or HIPAA, for short. HIPAA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange electronic health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical records.

Our Pledge Regarding Medical Information
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information
In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

Your Rights
You have the right to look at or get copies of your medical records and to receive a list of all the times we have shared your medical information for purposes other than treatment, payment, and health care operations.

Open Adjusting Concept
Because of the open adjusting concept in this office it is possible for doctor/patient discussions to possibly be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone
Patients may be contacted by mail or phone unless written notification is received requesting that contact be in only in person.

Complaints
If you feel that your rights have been violated, contact the Office Manager or The U.S. Department of Health and Human Services.

Acknowledgement

I have received the Notice of Practices and I have been provided an opportunity to discuss my right to privacy.

____________________	____________________	__________
PRINTED NAME	**SIGNATURE**	**DATE**

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CONSENT TO X-RAY

PATIENT CONSENT TO X-RAY

I authorize the performance of diagnostic x-ray examination of myself which my treating doctors or associates may consider necessary or advisable in the course of my examination and treatment.

Signed ____________________________________Date____________

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and my treating doctor and associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: ______________

Signed ____________________________________Date____________

CONSENT TO X-RAY MINOR CHILD

I authorize the performance of diagnostic x-rays and diagnostic examination of my child or ward which the doctors or associates may consider necessary or advisable in the course of examination and treatment. The patient _______________________________ is a minor of _________ years of age.

Signed ____________________________________Date____________

MEDICALLY UNNECESSARY RELEASE

I have been informed by Hobart Family Chiropractic that Medicare Part B will deny as medically unnecessary billing for radiology services rendered to me. I feel that services are necessary; however, in the event that Medicare should deny payment, I agree to be personally and fully responsible for payment.

Signed ____________________________________Date____________

RELEASE AND TRANSFER OF RECORDS

In the event that my treating doctor need specifications about an uncertain reading on your x-rays, an x-ray consultant services may be required. I allow Hobart Family Chiropractic to release my x-rays and diagnostic reports to any professional x-ray reading consultants they might use at this time. I understand that this service would be used for my safety and a consultation fee may be charged to my account.

Signed ____________________________________Date____________