

# New Patient - Health History Form

## Peak Performance Chiropractic Center

First:	<input type="text"/>	MI:	<input type="text"/>	Last:	<input type="text"/>		
Suffix:	<input type="text"/>	Name you prefer to go by:	<input type="text"/>				
Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip:	<input type="text"/>
Home Phone:	( <input type="text"/> ) <input type="text"/> - <input type="text"/>	Cell Phone:	( <input type="text"/> ) <input type="text"/> - <input type="text"/>				
Work Phone:	( <input type="text"/> ) <input type="text"/> - <input type="text"/>	Ext.	<input type="text"/>	Pager:	<input type="text"/>		
Email:	<input type="text"/>						

Gender: M <input type="radio"/> F <input type="radio"/>	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Other
Birthdate: <input type="text"/> / <input type="text"/> / <input type="text"/>	SS#: <input type="text"/> - <input type="text"/> - <input type="text"/>

Referred By: <input type="text"/>	Work Status: <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Other <input type="checkbox"/> Part-Time Student
Today's Date: <input type="text"/> / <input type="text"/> / <input type="text"/>	Appointment Reminder by Email? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Current Complaints

Nature of Injury: <input type="checkbox"/> Automobile* <input type="checkbox"/> Work <input type="checkbox"/> Other
Please Describe: <input type="text"/>
Date of Injury: <input type="text"/> / <input type="text"/> / <input type="text"/> Date Symptoms Appeared: <input type="text"/> / <input type="text"/> / <input type="text"/>
Have you ever had the same condition? <input type="radio"/> Yes <input type="radio"/> No If yes, when? <input type="text"/> / <input type="text"/> / <input type="text"/>
Practitioners seen for this condition/injury: <input type="text"/>
Have you ever been under chiropractic care? <input type="radio"/> Yes <input type="radio"/> No
If yes, please describe: <input type="text"/>

### Insurance Information

Party responsible for payment: <input type="text"/>	Phone: ( <input type="text"/> ) <input type="text"/> - <input type="text"/>
Do you have health insurance? <input type="radio"/> Yes <input type="radio"/> No	Name of Company: <input type="text"/>
<b>*If an auto accident, please provide:</b> Insurance Company: <input type="text"/>	
Contact Person: <input type="text"/>	Phone: ( <input type="text"/> ) <input type="text"/> - <input type="text"/>
Claim Number: <input type="text"/>	

### Signatures

Name of Insured (Print): <input type="text"/>	
<small>I understand &amp; agree that the health/accident insurance policies are an arrangement between an insurance carrier &amp; myself. I understand &amp; agree that all services rendered to me &amp; charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due &amp; payable. I understand that I am financially liable in the event of non-payment; I agree to pay any incurred collection agency fees &amp;/or attorney, &amp; court costs.</small>	
Patient's Signature: _____	Date: _____
Spouse's or Guardian's Signature: _____	Date: _____

## Medical History

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe

Date of last physical exam  Is there a chance that you are pregnant?  No  Yes

Have you had X-rays taken?  No  Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

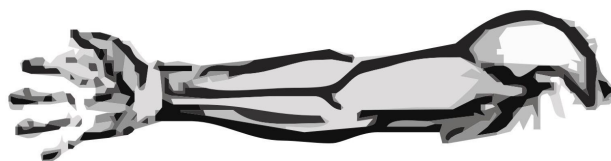
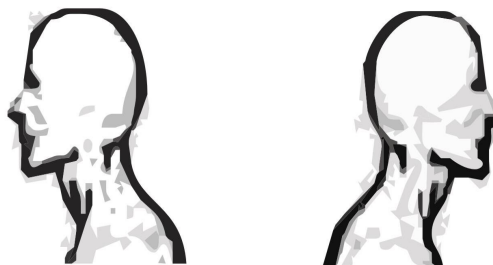
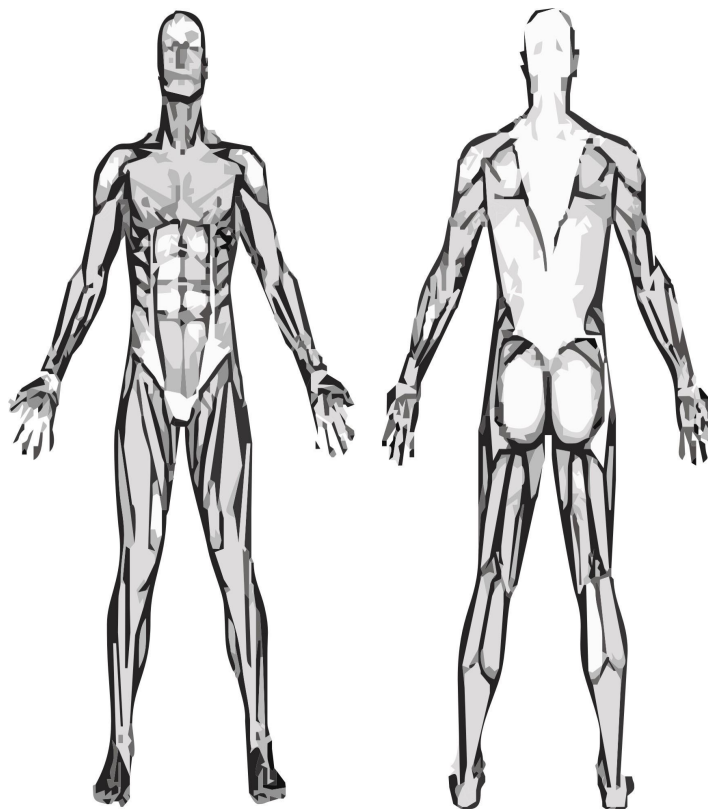
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A**=Ache                      **O**=Other
- B**=Burning                  **P**=Pins & Needles
- N**=Numbness                **S**=Stabbing



**PEAK PERFORMANCE CHIROPRACTIC CENTER**  
**373 B SCOTT COURT**  
**IOWA CITY, IA 52245**  
**(319) 354-7530**

**INTRODUCTION**

Welcome to our office, and thank you for taking the time to read about our chiropractic health care services. As our patient, your interest and well being are of primary concern to us.

**WHAT SHOULD YOU WEAR DRING TREATMENTS**

We prefer patients to wear two-piece outfits. We suggest pants and shirt or your favorite pair of sweatpants. We are then able to treat most patients in their clothes without the inconvenience of wearing a gown.

**CANCELING OR CHANGING APPOINTMENTS**

After each visit, your next appointment will be scheduled. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come back within 24 hours. If this is not possible, be sure to make up the missed appointment within a week. Statistics show that 90% of those patients, who don't miss appointments and follow the doctor's recommendation, get better results. Also, please be considerate to us and our patients. If you have to miss an appointment, please call at least 24 hours prior to the appointment so we may fill that time with another patient.

**DIETS AND FOOD SUPPLEMENTS**

Diets should be followed and food supplements taken as recommended by the doctor. We would appreciate hearing about any problems you may have with these recommendations. We do not prescribe medications but will make recommendations to help speed up your recovery. You are expected to pay for nutritional supplements at the time of purchase.

**PATIENT – DOCTOR AGREEMENT**

Our fees are about the same as those of other qualified comprehensive chiropractic health care practices. We never put money above people's health. All we ask is that you be honest about your financial situation. Tell us up front just how much you can stand financially, and we will do everything we can to help you. We will expect you to honor the financial arrangements you make with our office. If you cannot fulfill the agreement you have made with us, please notify the doctor immediately so new arrangements can be made.

Any checks sent to your home by the insurance company should be delivered or sent to our office within three days. Please also send attached stub to indicate which services were paid. Failure of the patient to make payment on an overdue account, or otherwise communicate with the doctor will result in prompt legal action. Payment is required on the first visit unless special arrangements are made with the doctor prior to examination.

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Initials

## **MAJOR MEDICAL GROUP HEALTH INSURANCE**

We will bill your primary insurance company and have you assign payment to us. When our office receives the insurance check, it will be credited to your account. It is your responsibility as the patient to know whether or not chiropractic care is a covered service under your insurance plan. It is also your responsibility to know what your deductible and co-pay or coinsurance amounts are. When you receive your Explanation of Benefits, please read it over carefully. If you do not understand it, please feel free to bring it to our office, and we will be glad to help you. Please note that it normally takes six to eight weeks after your first to receive payment from the insurance company. Therefore, all efforts will be made to keep your account as current as possible.

## **WORKER'S COMPENSATION**

Your employer has the sole right to decide whether to grant authorization for treatment or not. Your supervisor on the job may also grant authorization. In the State of Iowa, the employer has the right to tell you who to go to for treatment. If authorization is refused, the patient may undergo treatment at their own expense. Your coverage provided by major medical of group plan does NOT cover treatment for work related injuries. Worker's Compensation Insurance does not have to pay for supplements or orthopedic supports the doctor may recommend.

Patients involved in a worker's compensation case must bring either a signed authorization for treatment to our office or the name and phone number of the person who authorized their treatment, so that we can get a verbal authorization. Compensation cases that involve lawsuits are expected to be paid for by your insurance carrier or yourself (not attorney or court settlement). If your insurance carrier refuses payment, due to a lawsuit pending, you will be notified and the bill can be submitted to your group health insurance or paid by you. To aid us in this matter, please notify our office as to your attorney's name and address.

## **AUTO ACCIDENT**

Auto insurance or no fault insurance covers your health expenses resulting from an accident as long as the insurance company has been notified of the accident in a reasonable amount of time. Patients must notify their insurance company that they are being treated at our office and have forms sent to us directly. In the event that the auto insurance denies a portion of the claim or refuses payment, that portion will be your responsibility. If a lawsuit is involved with the accident, a lien form will be signed by you and your attorney ensuring us that we will be paid at the time of any court settlement.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that you will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to this office will be credited to my account upon receipt.

The undersigned further agrees to pay all costs of collection of any such balances, including attorney's fees. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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Initials

**PAYMENT METHOD AND RECEIPTS**

I understand that applicable co-pays or coinsurance is due at the time of service in the form of cash or check only. At time we are not set up to make credit/debit card transactions. Checks are to be made out to Peak Performance Chiropractic Center. You may request a receipt for your payment at any time. If a printed receipt is required, please allow five business days from the last date of service for processing.

**ASSIGNMENT OF CAUSE OF ACTION**

In the event any third party obligated to make payment to me or Peak Performance Chiropractic Center for the charges made for services refuses to make such payment upon demand, I hereby assign, transfer and convey to Iowa Peak Performance Chiropractic Center the cause of action that exists in my favor against any such company or person. I authorize Peak Performance Chiropractic Center to prosecute said action either in my name or their name to resolve said claim and collect legal expenses as they see fit.

I understand that I am financially responsible for all charges whether or not paid by a third party. I agree that all charges are payable and collectible in Johnson County. I hereby authorize Peak Performance Chiropractic Center to make inquiries, endorse drafts and to release any information to my insurance company, employer, attorney or benefit plan about my case.

I furthermore irrevocably authorize and direct any of these agents to pay what is due for professional services directly to Peak Performance Chiropractic Center. I give permission to the doctor to administer treatment and perform such general procedures as he deems necessary in the diagnoses and treatment of my condition.

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Signature of patient or guardian

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Date

Peak Performance Chiropractic Center

Consent To Use Protected Health Information For Treatment, Payment and  
Healthcare Operations

I consent to the use or disclosure of my protected health information by Peak Performance Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Peak Performance Chiropractic Center.

I have the right to revoke this consent, in writing, at any time, except to the extent that Peak Performance Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

## Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound or sensation in the area being treated.

In this office we use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that the portion of the brain that does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension - rotation-thrust adjustment." We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 38 No. 2, June 1993) estimate that the incident of this type of stroke is one per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatments (adjustments, traction, etc.) will aggravate the problem and rarely surgery may also cause a disc problem if the discs is in a weakened condition. These problems occur so rarely that there is no available statistics to quantify their probability.

Soft tissues primarily refer to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, chiropractic adjustment, traction, massage therapy, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there is no statistics to quantify their probability.

The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things such as osteoporosis. Osteoporosis can be noted on your x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Some of the machines we use generate heat. We also use heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur to rarely that there are no available statistics to quantify their probability.

It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them in advance of treatment.

Chiropractic is a system of health care delivery; therefore, as with any health care delivery system, disease, or condition nothing is guaranteed as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask the doctor. When you have a full understanding, please sign and date below.

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Patient's name printed

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Date

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Patient's Signature (Parent)