New Patient Demographics and Health History

Name: ____ Date: ______/______/______
(first) (middle) (last)

Mailing Address: ____ Apt/Unit: __________________

City: ____ State: _____________ Zip: _________________________

Home Phone: ____________________________________ Cell Phone: ____

Date of Birth: _______/_______/_______ Email: ____

May we email you treatment-related correspondence? Your info is never shared. Patient initials: YES: _______ NO: _______

Occupation: ____________________________________ Employer: ____

Emergency Contact: _____________________________________ Phone: _____________________________________

How did you hear about us?: ____

Is this visit routine/accident/illness/other: _______________________________ If Accident (date): __________________

PLEASE NOTE:
Any appointment missed and/or cancelled with less than 24-hours notice will be subject to a $35 fine. Patient initials: ________

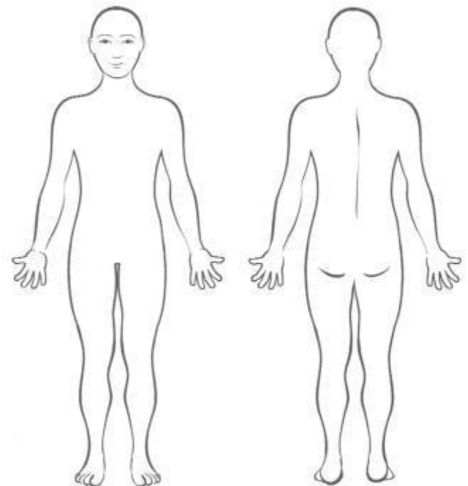
Condition(s): Please identify the health concerns that brought you to our office below / Mark your area(s) of pain on the figure below:

a. ____

Past Treatment____

b. ____

Past Treatment____



PAIN SCALE:

No Pain Moderate Pain Worst Pain

1 2 3 4 5 6 7 8 9 10

1. **Musculoskeletal** (please circle any you experience now and underline any you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): ____

2. **Neurologic** (please circle any you experience now and underline any you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

4. Do you have any reason to believe you may be pregnant?   Y   N   If so, how far along are you?__________________

5. Do you have any infectious diseases?   Y   N   If yes, please identify: ____

6. **Family History:** Circle illnesses that have occurred in a blood relative-

Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke
Mental Illness	Asthma/Hay fever/Hives	Kidney Disease	other:_______________________	

7. **Height:** __________   **Weight:** Currently: __________   Past Maximum: _________   When? __________________

8. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? _______

9. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
________________________	________________	________________________	________________

10. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
________________________	________________	________________________	________________

11. **Emotional** (please circle any you experience now and underline any you have experienced in the past):

Mood Swings   Nervousness   Mental Tension   Anxiety

12. **Energy and Immunity** (please circle any you experience now and underline any you have experienced in the past):

Fatigue   Slow Wound Healing   Chronic Infections   Chronic Fatigue Syndrome

13. **Head, Eye, Ear, Nose, and Throat** (please circle any you experience now and underline any you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

14. **Respiratory** (please circle any you experience now and underline any you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: ____		

15. **Cardiovascular** (please circle any you experience now and underline any you have experienced in the past):

Heart Disease | Chest Pain | Swelling of Ankles | High Blood Pressure

Palpitations/Fluttering | Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins

16. **Gastrointestinal** (please circle any you experience now and underline any you have experienced in the past):

Ulcers | Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Passing Gas | Heartburn

Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain

17. **Genito-Urinary Tract** (please circle any you experience now and underline any you have experienced in the past):

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Heavy Flow

Kidney Stones | Impaired Urination | Blood in Urine | Frequent Urination at Night

18. **Female Reproductive** (please circle any you experience now and underline any you have experienced in the past):

Irregular Cycles | Breast Lumps/Tenderness | Difficulty Conceiving | Heavy Flow/clotting

Vaginal Discharge | Premenstrual Problems | Bleeding Between Cycles | Menopausal Symptoms

19. **Menstrual/Birthing History:**

1. Age of First Menses: _______ 4. Birth Control Type: ________ 7. # of Abortions: ________

2. # of Days of Menses: _______ 5. # of Pregnancies: ________ 8. # of Live Births: ________

3. Length of Cycle: _______ 6. # of Miscarriages: ________

20. **Male Reproductive** (please circle any you experience now and underline any you have experienced in the past):

Sexual Difficulties | Prostrate Problems | Testicular Pain/Swelling | Penile Discharge

21. **Endocrine** (please circle any you experience now and underline any you have experienced in the past):

Hypothyroid | Hypoglycemia | Hyperthyroid | Diabetes Mellitus | Night Sweats | Feeling Hot or Cold

22. **Other** (please circle any you experience now and underline any you have experienced in the past):

Anemia | Cancer | Rashes | Eczema/Hives | Cold Hands/Feet

Is there anything else we should know? ____

23. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? ___________________

b. Exercise and spiritual practice:____

c. How many hours per night do you sleep? ________ Do you wake rested? Y N

d. Nicotine/Alcohol/Caffeine Use: ____

e. Have you experienced any major traumas? Y N Explain:_______________________________________

____

f. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Grand Rapids Wellness, PC
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Grand Rapids Wellness, PC. I understand that acupuncturists practicing in the state of Michigan are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. **Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.**

Acupressure/Shiatsu/Tui-Na Massage: I understand that I may also be given acupressure/shiatsu/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand I may stop the treatment at any time.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. **I give my permission and consent to treatment.**

Signature: ____ **Date:** _________________________

Printed Name: ____ **Date of Birth:** _________________

Acknowledgment of receipt of Notice of Patient Privacy Practices:

I have received the Notice of Patient Privacy Practices, which describes how Grand Rapids Wellness, PC may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This notice also describes my patient rights and the requirements of Grand Rapids Wellness, PC to protect my health information.

Grand Rapids Wellness, PC reserves the right to change the privacy practices that are described in the Notice of Patient Privacy Practices. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time and discuss its contents with the Privacy Officer.

The most current copy of this notice will be posted in the clinic.

Signature of Patient or Personal Representative:_________________________________ Date:_________________________

Printed name of Patient or Personal Representative:______________________________

Description of Personal Representative's authority:_______________________________

Dr. Doug deVries, DC Chiropractor
Acknowledgement and Consent to Treatment Form

To Our Patients:
Chiropractic examination and therapeutic procedures (including spinal and extraspinal adjustment, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. Additional information on side-effects, complications, and effectiveness of spinal adjustments is available upon request.

Please initial each item below.

_______ I hereby authorize Grand Rapids Wellness, PC to provide Chiropractic Services for me.

_______ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Grand Rapids Wellness, PC. This includes fees for new patient exams (For example: Priority does not cover new patient intake. BCBS members may have to pay out-of-pocket for a new patient exam if you've seen another chiropractor in the last 12-36 months)

_______ I understand that if I have an HSA, it will be treated as cash.

_______ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_______ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, private insurance and all other health plans, to Grand Rapids Wellness, PC.

_______ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

_______ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with Dr. deVries because it may affect care.

_______ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Grand Rapids Wellness, PC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

_______ I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Grand Rapids Wellness, PC and Dr. Doug deVries, DC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

I have read and understand the above statements regarding treatment side-effects. I also understand there is no guarantee or warranty for a specific cure or result. By signing this acknowledgement I affirm under penalty that I have given true complete information.

Patient signature: ____ Dated this ______ day of __________________ 20____.

Responsible Party Information (if not patient)

Name of financially responsible person: ____

Relationship to patient: __________________________________ Phone: ____

Mailing address: ____

Employer: ____ Employer Phone: _________________________________

Name of Insurance: ________________________________ ID#: _____________________ Grp#: ___________________