Bender Chiropractic Health and Vitality Center
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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Name: _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past Accidents or injuries: _____

_____

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED: _____ DATE _____

WELLNESS CHECK QUESTIONNAIRE

Thank you for taking the time to complete the Wellness Check Questionnaire.

YOUR FULL NAME

First Name

Last Name

Please fill out the following questions to the best of your ability.

	Rare / Never	1-3 times a month	1+ times per week / New condition
1. Stomach Discomfort	○	○	○
2. Lung Congestion	○	○	○
3. Dehydrated or thirsty	○	○	○
4. Gas-type indigestion	○	○	○
5. Circulation problems	○	○	○
6. Intestinal upsets	○	○	○
7. Yeast infections	○	○	○
8. Burping or belching	○	○	○
9. Hoarseness or laryngitis	○	○	○
10. Swollen feet	○	○	○
11. Fats hard to digest	○	○	○

12. Sweat easily	○	○	○
13. Alcohol intolerance	○	○	○
14. Constipation	○	○	○
15. Cold sores	○	○	○
16. Nose discharge or dryness	○	○	○
17. Bladder problems	○	○	○
18. Earaches	○	○	○
19. Restless sleep	○	○	○
20. Abdominal bloating	○	○	○
21. Athlete's Foot	○	○	○
22. Mucus in throat	○	○	○
23. Sensitivity to touch	○	○	○
24. Sensitivity to cold air	○	○	○
25. Grinding of teeth	○	○	○
26. Mood swings	○	○	○
27. Variable appetite	○	○	○
28. Crave carbohydrates	○	○	○
29. Gums bleed easily	○	○	○
30. Skin rash/irritations	○	○	○
31. Urination problems	○	○	○
32. Finger nail problems	○	○	○
33. Burning in soles of feet	○	○	○
34. Nose itches	○	○	○
35. Crave sugar-type foods	○	○	○

36. Feelings of nausea	○	○	○
37. Eczema or dry skin	○	○	○
38. Hearing/Ear sensitivities	○	○	○
39. Jaw problems	○	○	○
40. Headaches from the sun	○	○	○
41. Loss of libido	○	○	○
42. Film/Coating on tongue	○	○	○
43. Allergy-type symptoms	○	○	○
44. Anxiety/Nervous feelings	○	○	○
45. Carpal Tunnel symptoms	○	○	○
46. Lack of balance	○	○	○
47. General flu symptoms	○	○	○
48. Arthritic pain	○	○	○
49. Fatigued and irritable	○	○	○
50. Overly sensitive	○	○	○
51. Sensitive scars on body	○	○	○
52. Lack of coordination	○	○	○
53. Body achiness	○	○	○
54. Tooth pain	○	○	○
55. Hay Fever symptoms	○	○	○
56. Weeping or sobbing	○	○	○
57. Localized itching	○	○	○
58. Acid Reflux symptoms	○	○	○
59. Sinus/Head pressure	○	○	○

60. Muscular pain/spasm	○	○	○
61. Dizziness or vertigo	○	○	○
62. Dry mouth	○	○	○
63. Stiffness in joints	○	○	○
64. Stomach cramping	○	○	○
65. Sore throat	○	○	○
66. Overexertion pain	○	○	○
67. Migraines or headaches	○	○	○
68. Voracious appetite	○	○	○
69. Strained ligaments	○	○	○
70. Trouble swallowing	○	○	○
71. High temperature/fevers	○	○	○
72. Bone pain	○	○	○
73. Sporadic low back pain	○	○	○
74. Feeling overworked	○	○	○
75. Hemorrhoids	○	○	○
76. Heartburn-type pain	○	○	○
77. Ears feel under water	○	○	○
78. General aches and pain	○	○	○

Submit

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, [illegible] of h[illegible]ttributed to aspirin use [illegible]as 1[illegible] risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Bender Chiropractic Health & Vitality Center

New Patient Cancellation Policy

Welcome to Bender Chiropractic Health & Vitality Center! We look forward to serving you on your healthcare journey!

We are reserving about an hour for you to meet with your doctor and our clinical assistant, so short-notice cancellations create a large gap in our schedule where we could be helping other patients.

Because of that, we ask for at least a 24-hour notice if you need to cancel orreschedule your appointment. You can call anytime, just be sure to leave avoicemail with a detailed message if you are calling after hours.

Ifwe don’t receive a 24-hour notice, a $25 cancellation fee will be charged toyour credit card on file.

Thank you!

_____ _____

Signature Date

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Bender Chiropractic Health and Vitality Center

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:
Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-738-6833
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____(you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

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Staff complete only if NO signature is obtained, If it is not possible to obtain the patient s acknowledgment, describe the good faith efforts made to obtain the individual s acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
Other:

_____

Staff Signature: _____date: _____