



Welcome to Black & Gold Chiropractic & Wellness

At Black & Gold Chiropractic it is our mission to help you achieve all of your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess this and to understand the root cause of your symptoms, we will be taking you through a series of non-invasive examinations on your initial visit. This will include a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, and blood pressure.

On the day of your visit we ask that you wear clothing that you are comfortable moving in for the physical portion of the examination. We will be taking a postural photo of you so please don't wear bulky clothing or multiple layers. Ladies, if you have full tights or pantyhose on, we'll ask that you remove those. In addition to this, if you have any previous X-ray or MRI reports please bring these along on this visit for our records if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take between 45-60 minutes so we ask that you allow sufficient time and if you have any concerns please speak to our reception before your visit if time is a constraint.

PLEASE NOTE:

We do enforce a 24 hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late, you do run the risk of our Doctor being unable to see you. If this is the case, please contact our reception staff at 319-337-6000.



Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Date: _____ Social Security # _____

Name: _____
Last First M.I

Address _____

E-mail (Drs will communicate with you via email) _____

Cell Phone: _____ Home Phone: _____

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____

Sex: ___ Male ___ Female Age: _____ Birthdate: _____

___ Married ___ Separated ___ Widowed ___ Divorced ___ Single ___ Partnered for ___ Yrs ___ Minor

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

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

Patient Employer/School _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SS# _____ - _____ - _____ Phone: _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes___ No___ Date of Accident _____

Type of Accident: Auto ___ Work ___ Home ___ Other ___



INSURANCE INFORMATION:

Even if you are here through a non referral source such as a external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Jacob Young and/or Jessica Young all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to Black & Gold Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature Date

Clinical Summary (a required EMR question)

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.)*



Financial Responsibility

Patient Name _____

Dear Patient,

Black & Gold Chiropractic & Wellness provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

I have read and understood all the above information.

Patient Signature

Date

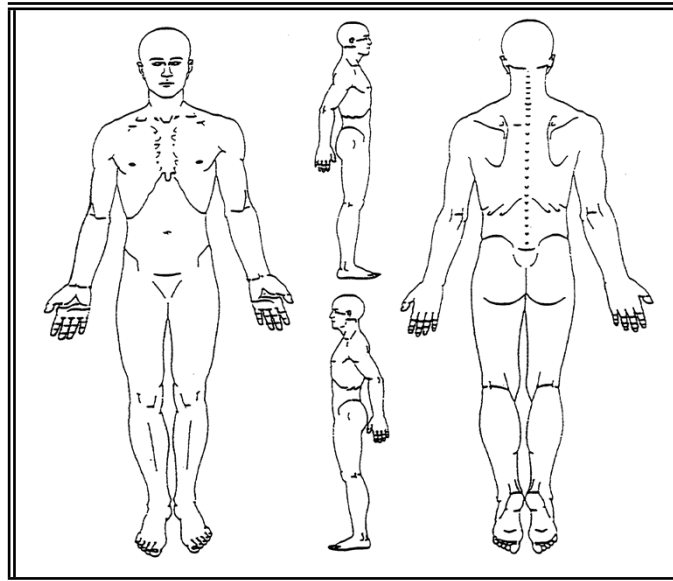


We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX // // // // // // // O O O O O O O O O S S S S S - - - - -
DULL/ACHY SHARP/STABBING NUMBNESS/TINGLING STIFF/TIGHT BURNING



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

- 0 = No Pain.** No Discomfort
- 1 = Minimal Discomfort.** Minor stiffness or tightness.
- 2 = Discomfort.** Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain.** More than just sore. Uncomfortable.
- 4 = Mild Pain.** Noticeable pain but tolerable.
- 5 = Moderate Pain.** Aggravating. Still allows movement.
- 6 = Strong Pain.** Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain.** Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain.** Extremely aggravating. Movement very limited.
- 9 = Severe Pain.** Brings tears. Almost impossible to move.
- 10 = Excruciating Pain.** Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time) _____

Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time) _____



Intermittent (0 – 25% of the time) _____

List any MD's or Chiropractors you've already seen for this problem: _____

What tests have you already had for this problem? X-rays MRI C.T. Scan Myelogram EMG/NCV

None Other _____

What makes your problem worse? Sitting Standing Changing Position Walking Bending Lifting Twisting

Reaching Driving Sleeping Sneeze/Cough Computer Work Telephone Going From Sit To Stand

Other _____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

Please list any surgeries you have had over the course of your life: _____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? Yes No If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use: _____

FAMILY HISTORY

Mother: Living Deceased List any medical problems: _____

Father: Living Deceased List any medical problems: _____

List any problems common in your family: Cancer Diabetes Heart disease High blood pressure Stroke Arthritis

Scoliosis Thyroid disease Osteoporosis _____

SOCIAL HISTORY

Marital status: Married Single Divorced Common Law Engaged Widowed

Do you have any children? Yes No If yes, how many? _____

Do you drink alcohol? Yes No If yes, how much & how often? _____

Do you smoke? Yes No If yes, how much, how often & how long? _____

Are you currently employed? Yes No If yes, what is your occupation? _____

Who is your current employer? _____ How long have you been at this job? _____

What do you do most of the day in your job postures, positions and repetitive movements: _____

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____ = _____



REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom

1 = Occasionally have this symptom, effect not severe

2 = Occasionally have this symptom, effect is severe

3 = Frequently have this symptom, effect not severe

4 = Frequently have this symptom, effect is severe

Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy/Activity: <input type="checkbox"/> Fatigue/Sluggishness <input type="checkbox"/> Apathy/Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Lungs: <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Difficulty Breathing
Eyes: <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	Weight: <input type="checkbox"/> Binge Eating/Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Heart: <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
Ears: <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage From Ear <input type="checkbox"/> Ringing In Ears, Hearing Loss	Emotions: <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety/Fear/Nervousness <input type="checkbox"/> Anger/Irritability/Aggressiveness <input type="checkbox"/> Depression	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal/Stomach Pain
Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	Mind: <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred speech	Other: <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
Mouth & Throat: <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores	Joints/Muscles: <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	Grand Total: