EXCEL FAMILY CHIROPRACTIC & WELLNESS, INC.
820 Geneva Pkwy N, Ste 105
Lake Geneva WI 53147
Phone: 262-248-6700 Fax: 262-248-6764 Email: frontdesk@excelfamilychiro.com

Acct # _____

Patient Name:_____ **Date:** _____

Address_____City/State_____Zip Code _____

Home. Phone_____Cell:_____ Work. _____

Email Address:_____ Sex: **M** **F** (*Please circle*) Date of Birth: _____

Referred by: _____

Have you ever received chiropractic care? (*Please circle*) **Yes** **No** If yes, when? _____

Name of most recent Chiropractor:_____

Health History:

1. Previous Injury or Trauma:

2. Have you ever broken any bones? Which?

3. Allergies:

4. Medications:

5. Surgeries:
   Date Type of Surgery
   _____
   _____
   _____

Family Health History:

Do you have a family history of? (*Please indicate all that apply*)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____□ None of the above

Social and Occupational History:

Job description:
_____

Level of Activity? (*Please check one)* _____High_____Medium ____Low

Do you smoke/use tobacco? YES NO Frequency _____

Do you consume alcohol? YES NO Frequency _____

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Patient Name:_____

Review of Systems (*Please check all that apply)*

- □ Anemia
- □ Asthma
- □ Bladder Infection
- □ Congestive Heart Failure
- □ Constipation
- □ COPD
- □ Depression
- □ Diabetes Type 1
- □ Diabetes Type 2
- □ Dialysis
- □ Difficulty Swallowing
- □ Emphysema
- □ Frequent Abdominal Pain
- □ Gastro Esophageal Reflux
- □ Gout
- □ Heart Attack/MIs
- □ Heart Surgery
- □ Hepatitis or Liver Disease
- □ Hiatal Hernia
- □ HIV Positive
- □ Hormone Replacement Therapy
- □ Hypertension
- □ Irregular Heartbeat
- □ Irritable Bowel/Colitis
- □ Kidney Disease
- □ Loss of Sense of Smell
- □ Metal Implants
- □ Murmurs or Valvular Disease
- □ Osteoarthritis
- □ Pacemaker
- □ Pancreatic Disease
- □ Psychiatric Diagnosis
- □ Renal Calculi/Stones
- □ Rheumatoid Arthritis
- □ Scoliosis
- □ Seizures
- □ Skin Grafts
- □ Strokes/TIAs
- □ Thyroid Disease
- □ Tremors
- □ Ulcerative Disease
- □ Vertigo
- □ Visual Changes/Loss of Vision

Other: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with State of Wisconsin statutes.

Patient or Guardian Signature_____ Date_____

EXCEL FAMILY CHIROPRACTIC & WELLNESS, INC. **Patient Name:**_____

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PATIENT SYMPTOM FORM
Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Primary Symptom:

1. Exact Location (right, left, front, back, etc.) _____
2. Cause of symptoms? _____
   - Did the symptom begin suddenly or gradually? *(please circle one)*
   - Describe how the symptom began? _____
   - Describe the quality of the symptom (circle all that apply):
     Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
     _____
3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
4. What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
5. Does the symptom radiate to another part of your body (*please circle one*): Y**es No**
   - If yes, where does the symptom radiate? _____
   - Is the symptom worse at certain times of the day or night? *(please circle)*
     Morning Afternoon Evening Night Unaffected by time of day
6. What makes the symptom worse? *(please circle all that apply):*
   - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left or right, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:
     _____
7. What makes the symptom better? *(please circle all that apply):*
   - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
   - Other *(please describe):*
     _____

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Patient Name: _____

Secondary Symptom:

1. Exact Location (right, left, front, back, etc.) _____

2. Cause of symptoms? _____

   - Did the symptom begin suddenly or gradually? *(please circle one)*
   - Describe how the symptom began? _____
   - Describe the quality of the symptom *(please circle all that apply):*
     Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
     _____

3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

4. What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

5. Does the symptom radiate to another part of your body (*please circle one*): Y**es No**
   - If yes, where does the symptom radiate? _____
   - Is the symptom worse at certain times of the day or night? *(please circle)*
     Morning Afternoon Evening Night Unaffected by time of day

6. What makes the symptom worse? *(please circle all that apply):*
   - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left or right, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:

     _____

7. What makes the symptom better? *(please circle all that apply):*
   - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
   - Other *(please describe):*

     _____

EXCEL FAMILY CHIROPRACTIC & WELLNESS, INC. **Patient Name:**_____

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INFORMED CONSENT FOR TREATMENT

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 involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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. Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____
Signature of patient or authorized guardian Date

_____
Print patient name

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Excel Family Chiropractic & Wellness may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____

Date of Birth: _____

I. My Authorization

I authorize _____ to use or disclose the following health information:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition:

  _____
- ❑ My health information covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ❑ Other:_____

The above party may disclose this health information to the following recipient:

Name/Organization: _____

Phone: _____ Fax: _____ Email: _____

The purpose of this authorization is (check all that apply):

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ❑ Other: _____

  _____

This authorization ends:

❑ On (Date): _____ ❑ When I am no longer a patient of the practice.

❑ When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:

- ❑ Patient is a minor: _____ years of age
- ❑ Patient is unable to sign because: _____

Authorized Representative Signature: _____ Date: _____

Print Name of Representative: _____

Authority of representative to sign on behalf of patient:

❑ Parent ❑ Legal Guardian ❑ Court Order ❑ Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

V. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Excel Family Chiropractic & Wellness Inc.
820 Geneva Parkway N Ste 105
Lake Geneva WI 53147
262-248-6700

Patient Financial Policy

Excel Family Chiropractic will provide insurance billing for you as a courtesy. We offer Time of Service Discount Rates if you do not have insurance or choose not to bill your insurance.

Please review your billing choices below and choose one option.

☐ **Patients who choose to bill insurance:**

- I understand any quote of benefits from my insurance company is not a guarantee of payment
- I authorize payment of my insurance benefits directly to Excel Family Chiropractic & Wellness Inc.
- I authorize Excel Family Chiropractic to release all information necessary to communicate with payers to secure payment of charges and collection agencies.

☐ **Patients who choose to self-pay:**

- I understand payment is due at the time of service

As a patient of Excel Family Chiropractic & Wellness, Inc. I am ultimately responsible for any charges incurred in this office.
By signing below, I indicate that I've read, understand, and agree with the terms on this page and have been offered a copy of Excel Family Chiropractic's Fee Schedule.

_____ _____

Signature of patient or authorized guardian Date

_____

Print patient name

Updated February 2021

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "Informed Consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provisions of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following:

1. I understand my treatment may create circumstances, such as discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.
2. I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
3. I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.
4. I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
   *Fever *Dry Cough *Sore Throat *Shortness of Breath
   *Runny Nose *Loss of Taste or Smell
5. I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) outside of the United States 2) domestically within the Unites States by commercial airline, bus or train.
6. I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your office to proceed with providing care.
7. I have been offered a copy of this consent form

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. 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 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 CARE FROM THIS OFFICE.

Patient	Parent/ Guardian	Witness
Signature: _____	Signature: _____	Signature _____
Name: _____	Name: _____	Name: _____
Date: _____	Date: _____	Date: _____