Dr. Neal Wieder, Chiropractor, Clinical Nutritionist, Certified in Acupuncture

PATIENT UPDATE FORM 2018

PERSONAL INFORMATION

PLEASE PRINT

First Name: _____ **M.I.** ____ **Last Name:** _____ **Preferred Name:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Birthdate:_____/_____/_____ **Age**_____ **Gender:** □ Male □ Female □ Unspecified **SSN:**_____/_____/_____

Primary Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Home Email:_____ **Work Email:**_____

By providing my email address, I authorize my doctor to contact me via the email, mail, phone & address(es) provided.

Which email would you like us to use to communicate with you? (Check one) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Emergency Contact: (Name, Relationship, Phone#)_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

Primary Insurance Carrier:_____ Phone:_____

Policy#_____ Group #_____ Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____ Employer:_____

Is patient covered by another insurance? □ Yes □ No **Secondary Insurance Carrier:** _____Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Neal Wieder, DC, DCBCN & Pure Chiropractic & Natural Health, PA, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: _____

(X)_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? Circle all that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

Are you interested in learning more about acupuncture? □ Yes □ No

On the scale below, please circle the severity of your main complaint right now:

No Pain *Moderate Pain* *Worst Possible Pain*

0	1	2	3	4	5	6	7	8	9	10

PATIENT HISTORY

Name:	Address:		
City:	Zip:	State:	Birthdate:

ILNESSES: Check "Y" if you have had any of these illness/problems or "F" if a family member has had any of the illness/problems

Y	F	Illness/Disease	Y	F	Illness/Disease	Y	F	Illness/Disease
		Alcoholism			Eye Problems			Rheumatic fever
		Anemia			Glaucoma			Rubella, German Measles
		Anesthetic Reaction			Heart Disease			Stroke
		Asthma			High Blood Pressure			Suicide Attempt
		Cancer, Tumor			Kidney Bladder Problems			Thyroid Disease
		Diabetes			Liver Disease (hepatitis/jaundice)			Ulcer (Stomach/Duodenum)
		Drug Abuse			Lung Disease, Tuberculosis			Uncontrolled Bleeding
		Depression			Mumps, measles, Chicken Pox			Venereal Disease
		Eczema, hives, rashes			Nervous Breakdown/Mental Illness			Other
		Epilepsy			Phlebitis			

MEDICINE ALLERGIES: List those medicines to which you are allergic and the type of reaction for each:

_____

_____

MEDICATIONS YOU ARE TAKING: (please list all prescription and non prescription medications):

_____

_____

_____

_____

HOSPITALIZATIONS: (please list all illness/injuries/operations and the approximate year:

YEAR	Illness/Injury/Operation	Hospital	City/State

Have you ever had a blood transfusion? YES NO Any reaction to the transfusion? YES NO

Do you smoke? YES NO If yes, how many packs per day? _____ For how many years? _____

Alcohol Consumption YES NO If yes, how many drinks/day or week? _____

PREGNANCY HISTORY: please enter the number of: _____times pregnant_____premature births _____miscarriage_____abortion_____live births_____living children

List any complications: _____

Review of Systems Checklist

CONSTITUTIONAL		
☐ night sweats ☐ anorexia ☐ chills ☐ sweating	☐ recent illness ☐ fatigue ☐ fever ☐ insomnia	☐ malaise ☐ weight gain/obesity ☐ weight loss
EYES		
☐ blindness ☐ eye discharge ☐ eye redness ☐ eye floaters	☐ eye foreign body ☐ eye pain ☐ eye tearing ☐ eye trauma	☐ eyelid swelling ☐ eyelid pain ☐ vision change ☐ cataract
EARS/NOSE/THROAT/NECK		
☐ cancer ☐ ear wax ☐ cosmetic deformity ☐ dental pain ☐ dizziness ☐ facial fracture ☐ facial pain ☐ snoring	☐ facial weakness ☐ headache ☐ hearing loss ☐ hoarseness ☐ jaw pain ☐ lacerations of head or neck ☐ nose bleeds ☐ sore throat	☐ allergies ☐ nasal pain ☐ polyps ☐ neck pain ☐ oral pain ☐ sinus congestion ☐ sleep apnea
CARDIOVASCULAR		
☐ arrhythmia ☐ chest pain ☐ swelling	☐ fatigue ☐ high blood pressure	☐ palpitations ☐ fainting
RESPIRATORY		
☐ asthma ☐ congestion ☐ chest tightness	☐ cigarette smoking ☐ cough	☐ snoring ☐ vomiting
GASTROINTESTINAL		
☐ hemorrhoids ☐ hepatitis ☐ abdominal pain ☐ anorexia	☐ constipation ☐ diarrhea ☐ gas and bloating ☐ jaundice	☐ nausea ☐ vomiting
GENITOURINARY/ NEPHROLOGY		
☐ breast complaint ☐ flank pain ☐ genital lesion ☐ blood in urine ☐ impotence ☐ menopausal symptoms	☐ menstrual irregularity ☐ night urination ☐ pap smear abnormality ☐ pelvic pain ☐ penile pain and discharge ☐ pregnancy	☐ testicular mass ☐ testicular pain ☐ urinary urgency ☐ urinary frequency ☐ urinary incontinence ☐ vaginal discharge
MUSCULOSKELETAL		
☐ stiffness ☐ swelling ☐ pain in joints ☐ back pain ☐ sciatica	☐ bone fracture ☐ bone pain ☐ carpal tunnel syndrome ☐ joint complaint ☐ shoulder pain	☐ muscle weakness ☐ muscle pain ☐ neck pain ☐ osteoporosis
DERMATOLOGIC		
☐ eczema	☐ sores	☐ skin cancer

☐ mole change ☐ pigmentation change ☐ rash	☐ acne ☐ cyst ☐ melanoma	☐ skin lesion
NEUROLOGIC		
☐ dizziness ☐ headache ☐ hearing loss ☐ memory loss ☐ mental status change	☐ back pain ☐ limb pain ☐ neck pain ☐ facial pain ☐ seizure	☐ speech difficulty ☐ fainting ☐ weakness ☐ spasms
PHYCHIATRIC		
☐ alcohol abuse ☐ drug abuse ☐ anxiety ☐ depression ☐ psychosis	☐ disturbance of consciousness ☐ disturbance of emotion ☐ disturbance of memory ☐ disturbance of thinking ☐ suicidally	☐ eating disorder ☐ hallucinations ☐ mania
ENDOCRINE		
☐ diabetes ☐ elevated blood sugar ☐ elevated cholesterol	☐ hyperthyroidism ☐ hypothyroidism ☐ obesity	☐ chills
HEMATOLOGIC/LYMPHATIC		
☐ abnormal bleeding and bruising ☐ anemia		
ALLERGY/IMMUNOLOGY		
☐ nasal discharge ☐ food allergies		

Phone number: _____ **Cell:** _____ **Work:** _____
Social Security # _____ **Occupation:** _____
Email: _____ **Age:** _____ **Wt.** _____ **Ht:** _____
Referred by? _____
Main Problem? _____
Do you have any needs for skin tightening or skin rejuvenation? _____ **Do you have sun spots?** _____
Are you unhappy with any areas of your body or weight? _____

Traditional Chinese Medicine Checklist

List of herbs:

_____

_____

Time of day you feel the best? _____ **Favorite season?** _____
Favorite color to wear? _____

Menstrual issues? _____ **heavy** _____ **Irregular** _____
menopause _____
Age of first menses? _____

INFORMED CONSENT AND WAIVER

I, _____, do hereby voluntarily request to receive clinical services from _____. I voluntarily consent that these services may include examination using Traditional Chinese Methods, differential diagnosis based in Chinese Medicine theory and Five Element Stimulation, Therapeutic Massage, Manual Therapy, Lifestyle Counseling, Hot and Cold Packs, biofeedback, Kinetic Therapies and Qi Gong therapeutic breathing techniques. I acknowledge that no guarantees have been made to me as to the effect of such examinations, treatments, therapy or care of my condition.

I further acknowledge that none of the above services are meant to be considered by me as the WESTERN diagnosis or treatment of disease. Such treatment and examinations are used as an aid to help my body produce varied physiologic effects to heal itself. Several examples of physiologic effects are: stimulation of various gates within the Central Nervous System, production of serotonin, endorphins, norepinephrine and acetylcholine, B-endorphins and regulation of the autonomic nervous system to name a few.

I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment and any probable risks involved. I understand that I may refuse service at anytime. I recognize that I am responsible for my health and well being. It is my duty to stay informed of my assessment and treatment.

I understand that payment by cash, check or credit card is due at the time of service.

I understand that all the clinical information will be kept confidential.

_____

WITNESS

_____

PATIENT'S SIGNATURE

_____

DATE

MEDICARE PATIENTS ONLY

Notice of exclusions from Medicare benefits (NEMB)

There are items and services for which Medicare will not pay

- **Medicare does not pay for all of our health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.**
- **When you receive an item or service that s not a Medicare benefit, you are responsible for payment, personally or through any other insurance that you may have.**

The purpose of this notice is help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision, you should read this entire notice carefully. Ask us to explain, if you do not understand why Medicare will not pay. Ask us how much these items or services will cost you.

Medicare will not pay for:

1. Because it does not meet the definition of any Medicare benefit
2. Because the following are excluded* from Medicare benefits.
□ Physical, orthopedic and neurological examinations
□ X-ray procedures
□ Extremity manipulation
✓ Acupuncture–Patient will be charged 15.00 for the disposal of needles
□ Physiotherapy such as, but not limited to, ultrasound, electric muscle stimulation, interferential, intersegmental traction and diathermy
□ Rehabilitation services
□ Massage
□ Trigger point therapy
□ Biofreeze or other muscle analgesic balms
□ Orthopedic foot, back, pillow supports
□ Health care received outside the USA
□ Services by immediate relatives
□ Nutritional supplements
□ After hours or emergency services charges
□ Services paid by a governmental entity that is not Medicare
□ Services for which the patient has no legal obligation to pay

***This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare Program provisions are contained in relevant laws, regulations and rulings.**

_____ _____

Patient's Signature **Date**