WELLSPRING

NEW PATIENT INTAKE FORM

Name: _____ Nickname:_____ SS#_____

Birthdate:____/____/_____ Age: _____ Sex: M☐ F☐ Marital Status: S☐ M☐ W☐ D☐

Phone:_____ Email:_____

Address: _____ Apt: #_____

City: _____ State: _____ Zip: _____

Employer: _____ Position: _____

Spouse: _____ Spouse DOB: _____/____/_____

Children (Names & Ages): _____

Emergency Contact: (Name/Relation)_____ (Number)_____

Do you have any records that we need to request? Yes☐ No☐

Primary Care Physician: _____ Did she/he refer you? Yes___ No___

How did you hear about our office? _____

Insurance Company Name: _____

Insured DOB: _____/_____/_____

Assignment of Insurance Benefits

I assign the payment of benefits due to me under my insurance policy with my carrier, and my direct insurance carrier to pay for all services rendered directly to Wellspring Health and Sports Performance.

Release of Medical Information to Insurance Carrier

I give permission to Wellspring Health and Sports Performance to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims.

Informed Consent Agreement

If I do not understand the necessity for, or the risk of, any therapy of manipulative procedure used in my care, I may request an explanation before performed so that I may give informed consent or objection.

Consent to treat a Minor (if applicable)

I hereby authorize Dr. Kampfe and his assistants to administer the medically necessary chiropractic care and therapy, as they deem necessary, and without my presence when necessary, to the above names patient, my _____ (relationship to minor).

I sign here for consent to treat my minor: _____

****All the above and following confidential health information has been read and is completed as true by the below signed individual who is responsible for the answering of these statements and the balance of payments on these accounts:**

Signature: _____ Date: _____

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- What is your major complaint and when did it start: _____
  How long does it last? _____ How frequently does it occur? _____
  Is it reoccurring? Yes☐ No☐ If yes, when did you first notice the problem? _____
- What caused this problem? _____
- Describe the pain: Sharp:☐ Dull:☐ Numbness:☐ Tingling:☐ Aching:☐ Burning:☐ Stabbing:☐
  Other:_____ _____
- What makes your complaint better or worse? _____
- Has any doctor treated you for this condition? Yes☐ No☐ Doctor: _____ When? _____
- Did you find your prior treatments helpful? Yes☐ No☐
- Have you had any chiropractic or muscle therapy for this condition in the past? Yes☐ No☐
- Any: X-Rays: _____ MRI: _____ Medication: _____ Injections: _____
- Other/ Results: _____
- Have you ever been given a permanent impairment rating? Yes_____ No_____
- Are there any conditions you have that may be related to your complaint? Yes_____ No_____
- If yes, please describe: _____

Accident/Injuries

	Describe Injury	Age
Falls	_____	_____
Sports	_____	_____
Auto Accidents	_____	_____
Other	_____	_____

System Review Please check all which have applied to you in the past year

☐ Dizziness/loss of balance/fainting	☐ Problems sleeping due to pain	☐ Bowel problems: constipation/diarrhea
☐ Eye pain/temple pain/face pain	☐ Unexplained fatigue/loss of focus	☐ Changes – urinary habits: more/less
☐ Jaw pain/TMJ problems/swallowing	☐ Low back pain/soreness/stiffness	☐ Knee, feet, or ankle pain
☐ Drug reactions	☐ Hurts to cough/sneeze/move bowels	☐ Frequent/painful/burning urine
☐ Arthritis/stiff joints	☐ Buttocks/hip/tailbone pain	☐ Chest/ribcage pain/tightness/pressure
☐ Bowel problems: constipation/diarrhea	☐ Other pain/numbness/tingling	☐ Visual disturbances/blurry/double
☐ Nausea/vomiting/vertigo	☐ Loss of muscle strength	☐ Difficulty breathing/painful breathing
☐ Restricted movement-neck	☐ Swollen feet, ankles, or legs	☐ Problems sitting/lying/bending/standing
☐ Pain around collar bone/front of neck	☐ Pain between/under shoulder blades	☐ Problems sleeping due to pain
☐ Pain/numbness/tingling into legs/feet	☐ Problems walking: limp, drag foot	☐ Ear noises/hearing loss
☐ Chest/ribcage pain/tightness/pressure	☐ Pain/numbness/tingling into arms/hands	☐ Shoulder pain/dysfunction
☐ Forgetfulness/confusion/disorientation	☐ Problem rolling over/getting up, down	☐ Recurring headaches/migraine

☐ Other "new" pain_____

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NUTRITIONAL PROFILE

Medications

List ALL prescription drugs, antibiotics, over the counter used and why you are taking them/who prescribed:

_____

_____

Has your weight changed more than 10lbs in the past year? N: _____ Y: _____ #lbs:_____

Number of times you exercise each week: _____ for _____#minutes average.

Hours you sleep (average): _____ How many times do you wake up? _____ Dreams: Y: ____ N: ____

What time do you go to bed? _____ How long until asleep? _____ What time do you wake up? _____

List any stressors/relaxation methods you have: _____

List Vaccinations: _____

Last blood work date: _____Physician Ordering: _____

List ALL allergies: _____

Have you ever had any of the following therapies: Acupuncture, Neuromuscular, Herbal, Vitamin? If yes, Please list:

_____

Have you had any changes in Smell, Taste, Touch, Hearing, Vision, Balance, and Equilibrium lately? _____

Has your thyroid gland been tested in the past year? _____ Date of last test: _____

For Women Only

Are you pregnant? Y:☐ N:☐ Any chance that you are pregnant? Y:☐ N:☐ Do you use birth control? Y:☐ N:☐

If yes, please circle: Pills Condoms Shots Diaphragm Herbs Endometriosis Tubal Hysterectomy

Beginning date of last menstrual cycle:_____. Do you have painful periods? N:☐ Y:☐

Family History Review the disease categories and use the appropriate letter(s):

GP (grandparent) **F** (father) **M** (mother) **B** (brother) **S** (sister) **C** (child)

Aneurysms_____	Stroke/TIA/Blood Clots_____	Epilepsy/Parkinson's_____
Arthritis_____	Kidney/Liver_____	Emphysema/Lung_____
Asthma_____	Polio_____	Heart Attack_____
Alzheimer's_____	Mental illness/Depression_____	Thyroid_____
Cancer_____	Stomach/Pancreas_____	Sinus Infections_____
Diabetes_____	Multiple Sclerosis_____	High Blood Pressure_____
Headaches/migraines_____	Disc Degeneration_____	Tuberculosis _____

Significant Illness Check all that apply.

☐ Heart trouble	☐ High blood pressure	☐ Thyroid problems
☐ Cancer	☐ Diabetes	☐ Seizures/Stroke/TIA
☐ Mental/Depression	☐ Arthritis	☐ Asthma/Lung Disease
☐ Tuberculosis	☐ Colon/Stomach problems	☐ Liver/Kidney/Spleen
☐ Blood clots/Embolism	☐ HIV positive	Other_____

Have you ever had any surgery? No☐ Yes☐

Please Describe:_____

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Notice of Privacy Practices Acknowledgement Form

I acknowledge that Wellspring Health and Sports Performance has provided me with a copy of its Notice of Privacy Practices. I understand this acknowledgement means only that I have received the notice, and in no way affects the care I receive. I understand that Wellspring will contact me at home via phone or postcard regarding appointment reminders, information on treatment alternatives, services or goods and that it is my responsibility to notify the office should I choose not to be contacted regarding this. I understand that the initial examinations are completed in total privacy, but that routine chiropractic treatment is rendered in a semi-privately designed room.

Client Statement

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health. This is considered a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not seeking advice for medical or diagnostic purposes of treatment procedures. I am not on this visit/phone consultation, or any subsequent visit/phone consultation with an agent for federal, state or local agencies, or on a mission of entrapment or investigation. The services performed by Eileen Kampfe or others are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing or prescribing of remedies for the treatment of disease.

Financial Policy Statement

We appreciate your decision to select our office for your healthcare needs. Our goal is that you receive proper care needed to restore your health and ensure that you understand your condition. We hope that you understand our financial policy is a necessary part of operating a professional healthcare facility for our community. We have implemented the following financial policy and we ask that you read, agree and sign prior to seeing a provider. Payments for services are due at the time of service, unless prior arrangements have been made. We accept cash, check, credit and debit cards. We will send your insurance claim to your carrier as long as you provide us with your current insurance information. Currently we participate with Blue Cross Blue Shield, Florida Blue, and Cigna. Some plans require a referral/authorization from your primary care physician before we can render professional services under your policy. Correct identification of your policy will allow us to submit an accurate claim on your behalf. Maintenance care cannot be billed to a third-party insurance carrier.

- **Co-payments and deductibles are due at the time of service.**
- **If you miss a scheduled appointment without 24-hour notice, we reserve the right to charge the cost of the visit.**
- **Balances:** Not all services are covered under certain plans. Any charges not paid by the insurance companies are the responsibilities of the patient. Including Health Savings Accounts (HSAs). If your insurance does not pay in full within 45 days, we ask that you contact your insurance company to expedite payment. If your insurance does not pay in full within 60 days, we require you to pay the balance due within 10 days of notice. All balances older than 90 days will be reviewed and turned over to an outside collection agency if payment arrangements have not been resolved. If your plan requires a referral, you are required to obtain that referral prior to your appointment. If you do not obtain the referral, you are responsible for payment in full at the time of service. - We do not accept assignment on out of state policies that are not governed by the Florida Department of Insurance. We do not do secondary billing if you have a multiple policy benefits without an additional fee of $35 for filing. - Returned checks are subject to a $50 return check fee to cover bookkeeping and bank expenses. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we can assist you in the management of your account. Thank you for choosing us for your health care needs, and we appreciate the opportunity to serve you.

I, _____ (print name), have read the above policies and agree to its provisions.

Patient Signature _____ Date _____