Pure Chiropractic and Wellness
Dr. Breyan Radeck
2717 N. Grandview Blvd. Suite 101 • Waukesha, WI 53188

CONFIDENTIAL PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Birthdate: ____ - ____ - _____ Age: _____ SSN: _____

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Referred by: □ Our Website □ Phonebook □ Walk-In □ Insurance Company

□ A Current Patient: _____ □ Other: _____

Claim / Insurance Information:

Claim Type: □ Self - Pay □ Insurance □ Auto Accident □ Worker's Comp □ Personal Injury

Primary Insurance: _____ Policyholder's Employer: _____

Policyholder's Name: _____ Policyholder's Birthdate: ____ - ____ - _____

Relationship to Policyholder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance: _____ Policyholder's Name: _____

Authorizations:

Please initial by each statement and sign below to indicate your acceptance of stated terms:

_____ 1. I certify that I am the patient (or authorized representative of the patient) and all information I furnish is current, valid, and complete.

_____ 2. I authorize the release of all necessary medical information to any designated insurance carrier, attorney, or third-party administrator for claim processing and payment.

_____ 3. I assign all payments from any insurance carrier, attorney, or third-party administrator for medical services rendered to me (or my dependents) to be made directly to this clinic.

_____ 4. I understand that my payment (including co-pay, co-insurance, and deductible amounts) is due at the time of service. Payment plans can be arranged upon request.

_____ 5. I understand that I am personally responsible for full payment of all medical services rendered to me (or my dependents), regardless of insurance or financially-responsible-party coverage, partial payment(s), and/or termination of medical treatment.

Patient (*or Authorized Rep.*) Signature: _____ Date: _____

Authorized representative's relationship to patient: _____

Continue on other side →

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NOTICE OF PRIVACY PRACTICES (FEDERAL HIPAA PRIVACY ACT)

Effective Date for this Notice: February 2022

This notice describes how your protected health information may be used and disclosed, your rights as a patient, our legal duties with respect to your information, and how you can access additional information.

We may use or disclose your health information for the following purposes:

- **Treatment:** to all providers and staff within our clinic that are involved with your care; to other health care providers consulting with your care; and for contacting you about appointments, treatment options, and clinic-related information.
- **Billing and Collection:** to your insurance carrier and/or financially-responsible party to obtain payment for your medical services.
- **Health Care Operations:** for quality control; for office administration, development, and record-keeping; and for training providers and staff within our clinic.

Your rights with respect to your health information allow you to:

- Inspect and obtain a copy of your health record
- Amend your health record and/or request a restriction on certain uses and disclosures of your information
- Receive confidential communications by alternative means or locations
- Obtain a paper copy of notice upon request
- File a complaint regarding our privacy notice or practices

We are required by law to:

- Maintain the privacy of your protected health information
- Provide you with a notice of our privacy practices, including any future revisions
- Abide by the terms of this notice

Contact for additional information:

If you have any questions, concerns, or complaints about our privacy policies, your privacy rights, and/or your protected health information, please contact the **Clinic Privacy Director** at:

Pure Chiropractic and Wellness
2717 N. Grandview Blvd. Suite 101 • Waukesha, WI 53188
Phone: (262) 349-9370 • Fax: (262) 349-9729

CONSENT FOR TREATMENT

I hereby authorize all providers and staff at this clinic to perform treatment on me. Treatment may include, but not limited to: chiropractic adjustments, examinations, therapies, and x-rays. I understand that in any practice of medicine there may be risks or complications associated with treatment. I do not expect the provider(s) to be able to anticipate and explain all risks possible with chiropractic treatment, but I have been given the opportunity to ask questions and discuss my concerns. Therefore, I wish to rely on the judgment of the provider(s) during the course of my treatment and care, based on the facts then known.

I, _____, have read both the NOTICE OF PRIVACY PRACTICES and CONSENT FOR TREATMENT. I accept the terms of each.
Print Your Name

Patient (*or Authorized Rep.*) Signature: _____ Date: _____

_____
Witness Signature and Date

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TODAY'S CHIROPRACTIC VISIT

Patient Name: _____ Date: _____

Have you ever received chiropractic care? □ Yes □ No When? _____

Was previous care for the same reason as today's visit? □ Yes □ No

List your symptoms you wish to seek chiropractic care for today: _____

_____

_____

When did your symptoms begin? _____

How did your symptoms begin? _____

How often do you experience your symptoms?
- □ Constantly (75-100% of time)
- □ Frequently (50-75% of time)
- □ Occasionally (25-50% of time)
- □ Intermittently (0-25% of time)

What best describes your symptoms?
- □ Sharp
- □ Burning
- □ Dull
- □ Throbbing
- □ Numbness / Tingling – Where? _____
- □ Shooting / Radiating – Where does the pain travel to? _____

When are your symptoms the worst?
- □ Morning
- □ Evening / Night
- □ Afternoon
- □ Always the Same

Does anything ***ease*** your symptoms?
- □ Nothing Eases
- □ Sleeping / Resting
- □ Sitting
- □ Standing
- □ Stretching
- □ Walking / Exercise
- □ Heat
- □ Ice
- □ Medication
- □ Massage / Therapy
- □ Other: _____

Does anything ***aggravate*** your symptoms?
- □ Nothing Aggravates
- □ Sleeping / Resting
- □ Sitting / Driving
- □ Standing
- □ Stretching / Straining
- □ Walking / Exercise
- □ Sneezing / Coughing
- □ Bending
- □ Lifting / Pulling
- □ Turning
- □ Heat / Ice
- □ Massage / Therapy
- □ Other: _____

Circle the intensity of your symptoms:

0	1	2	3	4	5	6	7	8	9	10

No Pain → *Excruciating*

List any other care, treatments, tests, or medications you have received for your symptoms: _____

_____

_____

Please list any questions or concerns that you have: _____

_____

_____

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HEALTH HISTORY

List any medications you are taking: _____

_____

_____

Do you or have you ever had any of the following diseases or conditions?

□ Heart Conditions	□ Cancer	□ Asthma
□ Stroke	□ Chemotherapy / Radiation	□ Sinus Problems
□ Fainting / Seizures / Epilepsy	□ Alcohol / Drug Abuse	□ Headaches
□ HIV / AIDS	□ High Blood Pressure	□ Neck Pain
□ Tuberculosis	□ Low Blood Pressure	□ Back Pain
□ Shingles	□ Pacemaker	□ Sciatica
□ Diabetes	□ Artificial Bones / Joints	□ Arthritis

List any other serious medical conditions that you have or had: _____

_____

List any allergies: _____

_____

List any previous surgeries and treatments with dates: _____

_____

List any past serious accidents with dates: _____

_____

List any ***family*** health history that you feel is important to share: _____

_____

Do you take supplements? □ Yes □ No Please list: _____

_____

Do you exercise? □ Yes □ No Type of activity and consistency: _____

_____

Do you smoke? □ Yes □ No How much and for how long? _____

Do you wear shoe inserts? □ Yes □ No

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

For Females: Are you pregnant? □ Yes □ No □ Not Sure For how long? _____

Are you nursing? □ Yes □ No

Patient Signature: _____ Date: _____

Continue on other side →