Iowa Chiropractic and Performance Center
410 1st Ave., Coralville, IA 52241
P:(319) 351-9460 E: info@iachiropractic.com
www.iachiropractic.com

Welcome!

Thank you for selecting our chiropractic office!
We will strive to provide you with the best possible care.
To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____/_____/_____ Social Security # _____

Address _____ City _____ State ____ Zip _____

Cell phone# _____Home ph # _____

***E-mail**_____*

Occupation _____Patient's or Parent's Employer _____

Emergency Contact _____ Phone _____

**Whom may we thank for referring you? _____*

Primary Care Physician_____Permission to Contact? Yes / No

Have you ever received Chiropractic Care? Yes / No If yes, when? _____
Name of most recent Chiropractor _____

****Please include your email address on this form**.** *We may use it to more conveniently communicate in the event of the office being closed or needing to reschedule or send reminders from things we covered during your appointment. We do send an email 1-2 times per month on topics related to health, movement, or nutrition – if you would prefer to not receive that email and be included on that list, please check this box* ***[ ].***

Insurance Information (Not necessary to fill out if we copy your Ins. Card and Driver's License)

Name of Insured_____ Relation to Patient _____

Insurance Company _____Group # _____Policy # _____

How much is your deductible? _____How much have you used?_____ Max annual benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ***Yes / No***

Patient Name_____ Date: _____ **Iowa Chiropractic and Performance Center – Dr. Conrad Stalheim**
410 1st ave.,Coralville, IA 52241 ph: 319-351-9460

1.Past Medical History:

___Cancer ___Arthritis ___Alcoholism ___Kidney disease ___Diabetes ___Seizures ___Lung Disease ___Thyroid disease

___Ulcers ___Glaucoma ___Heart disease ___Tuberculosis ___AIDS/HIV ___Hepatitis __Diverticulitis

___High Blood Pressure ___Stroke ___Anemia ___Pacemaker ___Joint Replacement ___Blood Thinners

___Depression/Anxiety Other_____

Surgeries/Hospitalizations: Injuries/Fractures/Dislocations:

_____Year:_____

_____Year:_____

_____Year:_____

Allergies/Drug Allergies: _____

2. Family Medical History: (Grandparents, Parents, Siblings) ___Heart disease (below age 40) ___Cancer ___Lupus

___Diabetes ___ Rheumatoid Arthritis ___Abnormal bleeding ___Muscle disease ___Fibromyalgia ___Auto-Immune Disorder ___Drug Allergies

Living parents? Mother ___Yes ___No; Died at age _____ of _____
Father ___Yes ___No; Died at age _____ of _____

3.Social and Occupational History:

Job description: _____
Job Duties: _____
Recreational activities/Hobbies:_____

4.Lifestyle Habits:

Tobacco_____(# of cigs/day) How long have you smoked?_____(years)

Alcohol_____(# of drinks/day) or _____ (# of drinks/week)Caffeine beverages _____(#/day)

Do you exercise regularly? ___No ___Yes; Type_____Frequency_____(days/week)

Has your condition prevented you from doing exercise? ___Yes ___No

Sleep _____(hours/day) Age of Mattress: _____

5.List ALL medications you are currently taking or ***Provide the Front Desk w/ a List to copy***; or if you are a JPA patient let us know.

Medication Reason for taking

_____

_____

_____

_____

_____

Patient Name_____ Date: _____ **Iowa Chiropractic and Performance Center – Dr. Conrad Stalheim**
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Review of Systems: (Please Check ALL that apply) Have you ever had any of the following

Constitutional: ___Fever ___Night Sweats ___Unexplained weight loss
Eyes: ___abrupt change in vision
Ears, Mouth, and Throat: ___abrupt change in hearing ___Difficulty swallowing ___Sore throat
Cardiovascular: ___Chest Pain ___Poor circulation
Respiratory: ___Cough ___Difficulty Breathing ___COPD
Gastrointestinal: ___Nausea ___Vomiting ___Bleeding ___Diarrhea ___Ulc. Colitis ___IBS/Colitis ___Heartburn
Musculoskeletal: ___Painful or Swollen Joints __Rheumatoid arthritis ___spinal fractures ___Joint surgery
Skin: ___Rash ___Psoriatic disorders ___other
Neurologic: ___Dizziness ___Numbness ___Muscle weakness ___headaches ___Vertigo ___Strokes/TIAs
Endocrine: ___Hot flashes ___Decreased sexual interest or function ___Thyroid disease ___Hormone Replacement Ther.
Hematologic/Lymphatic: ___Bruise easily ___Anemia ___Regular Anti-inflammatory use (NSAIDs) ___Enlarged lymph nodes ___DVT/Clots
Allergic/Immunologic: ___Allergies to pollen Other Allergies_____
Genitourinary: ___Burning on urination ___Loss of bladder/bowel control ___difficulty urinating ___bladder infections
Infection (recent): ___Urinary tract ___Respiratory __Skin ___Immune system dysfunction Other_____
Psychosocial: ___Depression ___Anxiety ___Difficulty sleeping ___psychiatric diagnosis ___bipolar disorder

	Not at all	A little bit	Moderately	Quite a bit	Extremely	
Everything feels like an effort	0	1	2	3	4	Don't Know
Trouble getting your breath	0	1	2	3	4	Don't Know
Hot or cold spells	0	1	2	3	4	Don't Know
Numbness or tingling in parts of your body	0	1	2	3	4	Don't Know
Pain in your heart or chest	0	1	2	3	4	Don't Know

1. Rate your opinion on your current level of health – least healthy – 0 1 2 3 4 5 6 7 8 9 10 most healthy
2. How important is your health to you? Not important – 0 1 2 3 4 5 6 7 8 9 10 Extremely Important
3. If you are not currently satisfied with your level of health, what do you consider to be your barrier(s) motivation Information Overload Lack of information Not sure where to start Uninterested Genetics Other_____
4. If someone could quantify your level of health and explain to you how you are doing health wise and give you simple solutions to any health concerns how interested would you be? – Not interested – 0 1 2 3 4 5 6 7 8 9 10 – Very Interested
5. Is anyone currently helping you to manage your health? YES / NO

Is there anything else in your past medical history that you feel is important to your care here? _____

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 this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Iowa Chiropractic & Perf. Ctr for services performed.

Patient or Guardian Signature _____Date_____

HIPAA REQUIRED FORM – Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Patient consent to the use and disclosure of private health information for treatment, payment or healthcare operations.

I_____, understand that as a part of my healthcare, Iowa Chiropractic and Performance Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third party payer can verify that services billed were provided.

Should it become necessary to disclose my protected information to another health provider or 3rd party payer for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient Signature_____ Date _____

PATIENT INFORMED CONSENT TO TREATMENT

The Nature Of Chiropractic Treatment: Physical examination involves bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feeling sore or having worse pain. During treatment, the doctor will use his hands or mechanical devices in order to move your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is inherent in some of the joint manipulation procedures, and is a natural effect of joint movement. Various other procedures, including hot packs, electric stimulation, therapeutic ultrasound, exercises or deep massage may also be used.

Possible Risks and Side Effects: As soon as ANY doctor intervenes with your healthcare there is risk of side effects and complications. The risk of serious complications from chiropractic treatment has been described as "rare," estimated fewer than 300,000 complications over a **5**-year period (as opposed to about 300,000 deaths annually from prescription drugs). While complications are possible following a chiropractic treatment, most are highly unlikely, but could include fractures, sprains, dislocations, and injury to intervertebral discs, nerves or spinal cord. Osteopenic/osteoporotic patients are at higher risk of rib fracture from hands-on procedures. It is possible to experience worse symptoms or new symptoms. Ancillary procedures (e.g. hot packs or massage) could produce skin irritation, burns or bruises. Cerebrovascular accident such as a stroke could occur and has been calculated at one in a million to one in forty million odds, about the same odds of stroke from having your hair washed in a salon ("beauty parlor syndrome"). The most common and likely side effect of treatment is muscular stiffness or soreness that some people say feels like muscles they exercised for the first time. The odds of having minor adverse symptoms such as post-treatment soreness are about 30%, and these symptoms are often transient, lasing only a day (akin to having sore gums following teeth cleaning by a dental hygienist).

Other Treatment Options That Could Be Considered (Just To Put Things In Perspective):

Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all have significant risk of side effects or potentially serious complications.

Risks Of Remaining Untreated: While it is possible that your symptoms can go away with no treatment at all, delay of treatment or not following the doctor's recommended treatment plan could lessen or alter your chances of recovery.

I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. I freely decided to undergo the recommended treatment, and hereby give full consent to treatment.

_____ _____

Patient or Parent/Guardian **Date**

IOWA CHIROPRACTIC & PERFORMANCE CENTER FINANCIAL POLICY

Full payment is expected at the time of service. Payment is accepted via cash, check or credit card.

Appointment cancellations made less than 24 hours prior to your appointment will result in a charge of $50. It is very unlikely for us to be able to fill your time slot with such late notice.

If you have insurance that we are in network with, we will make a copy of your card and collect any co-pay that is due. Once we receive word from your insurance company, we will send you a statement if there is a balance that we are entitled to collect. We strongly advise you to contact your insurance company to discuss your benefit coverage for chiropractic services. Insurance coverage for chiropractic care varies greatly. If you still have questions, feel free to contact our office and we will do our best to assist you. A common patient co-pay is between $10-$25.

If you have insurance coverage where we are not an in-network provider you can contact your insurance company to see if they provide benefits when visiting an out of network provider. You will be responsible for providing payment at the time of service and we will file the claim for you if applicable.

Please be aware that some insurance companies require pre-certification for chiropractic care. Care will commence once approval has been obtained. Some insurance companies may also require a referral from your primary care physician. This is rare.

Dr. Stalheim is also a participating provider for **Medicare**. You will be required to read and sign the separate Medicare policy documentation if applicable.

If you have injuries that are the result of an automobile accident, worker's compensation, etc. we do accept assignment for personal injury claims.

ICPC is pleased to offer **EVERYONE** a **time of service discount**. A Time of Service Discount is a discount off of our standard fee schedule here at ICPC and **applies to patients that do not have insurance coverage**. This discount is available to any and all patients making payment at the time of service. There are many administrative costs and extra tasks that must be completed when processing insurance claims. A patient paying at the time of service greatly lessens this workload which allows us to pass a significant savings on to both the patient and their insurance company for those patients who submit their own claims to the insurance company for reimbursement. Please see the chart below for examples of our standard fee and TOS discount fee on some of our most common services.

Please feel free to discuss any financial concerns or difficulties you may have regarding your account. Early and open communication in these situations affords everyone the opportunity to reach a resolution suitable to all parties.

By signing below, I agree to the following: "I have read, understand, and agree with the preceding described financial policies. By signing I agree that I also understand that as the patient or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Iowa Chiropractic & Performance Center. Failure to pay all costs associated with my care as agreed may result in collection activity on my account as well as reporting of my payment history to credit reporting bureaus."

Patient Name: _____ X_____

(Please Print) (SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE)

Patient Name_____ **Date:** _____ Iowa Chiropractic and Performance Center – Dr. Conrad Stalheim
410 1st ave.,Coralville, IA 52241 ph: 319-351-9460

NEW PATIENT HISTORY FORM

Symptom #1 _____

What level would you rate your pain MOST OF THE TIME? (please circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

What ***percentage*** of the time **you are awake**
do you experience the above symptom at the above intensity:

10 20 30 40 50 60 70 80 90 100 %

Did the symptom begin **suddenly** or **gradually**? (circle one)

When did the symptom begin? _____
How did the symptom begin? _____
_____

Over the past **MONTH** has your pain…
__Improved __Worsened __Not changed
Over the past **WEEK** has your pain…
__Improved __Worsened __Not Changed

How do the following affect your pain?

	No change	Worse	Better
Cough/sneeze	_____	_____	_____
Sitting	_____	_____	_____
Sit to Stand	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Lying on stomach	_____	_____	_____
Looking down	_____	_____	_____
Looking up	_____	_____	_____
Turning head	_____	_____	_____
Lifting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Nighttime	_____	_____	_____
Morning	_____	_____	_____

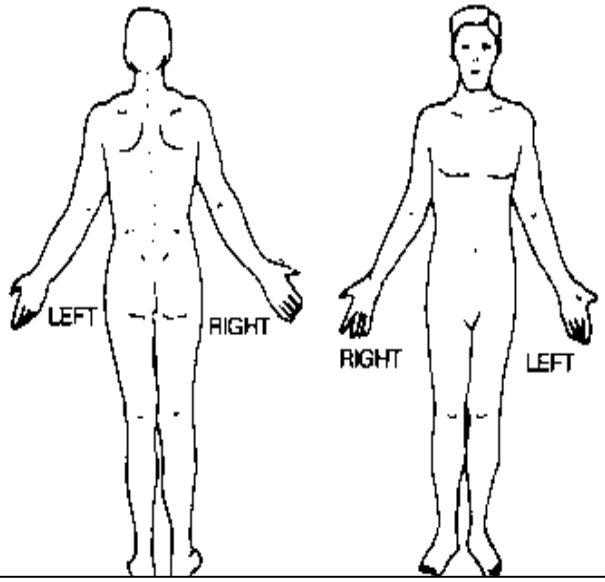
Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing,
piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____

Does the symptom **radiate (travel)**
to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please c
No difference Morning Afternoon
Evening Night Other _____

Please fill out the pain drawing below
Use these symbols on the drawings:

Ache: xxxx **Numbness: NNNN**
Burning: ++++ **Pins/Needles: PPPP**
Stabbing: ^^^^ **Other: - - - -**



GOALS:

List the FOUR ACTIVITIES OF DAILY LIVING that are impeded by your pain, and which you MOST DEARLY would want restored.

1.....

2.....

3.....

4.....

Prior tests for your pain:
X-ray_____
MRI_____
CT_____
Lab_____
Other_____

Prior treatment for your current problem:
Anti-Inflammatory (NSAIDs): __Ibuprofen __Aleve __Celebrex __Mobic
Other_____ Results: _____
Steroids: __Prednisone pills __Cortisone injection
Other _____ Results: _____
Injections:__Epidural __Facet __Other Results:_____
Spinal surgery: Year/Procedures/Results_____
Physical Therapy: Year/Procedures/Results_____
Chiropractic: Year/Procedures/Results_____
Other Treatments: Year/Type/Results_____

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NEW PATIENT HISTORY FORM

Symptom 2 _____

What level would you rate your pain MOST OF THE TIME? (circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

What ***percentage*** of the time **you are awake** do you experience the above symptom at the above intensity:

10 20 30 40 50 60 70 80 90 100 %

Did the symptom begin **suddenly** or **gradually**? (circle one)

When did the symptom begin? _____
How did the symptom begin? _____
_____

Over the past **MONTH** has your pain…
__Improved __Worsened __Not changed
Over the past **WEEK** has your pain…
__Improved __Worsened __Not Changed

Prior tests for your pain:
X-ray_____
MRI_____
CT_____
Lab_____
Other_____

Prior treatment for your current problem:
Anti-Inflammatory (NSAIDs): __Ibuprofen __Aleve __Celebrex __Mobic
Other_____ Results: _____
Steroids: __Prednisone pills __Cortisone injection
Other _____ Results: _____
Injections:__Epidural __Facet __Other Results:_____
Spinal surgery: Year/Procedures/Results_____
Physical Therapy: Year/Procedures/Results_____
Chiropractic: Year/Procedures/Results_____
Other Treatments: Year/Type/Results_____

How do the following affect your pain?

	No change	Worse	Better
Cough/sneeze	_____	_____	_____
Sitting	_____	_____	_____
Sit to Stand	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Lying on stomach	_____	_____	_____
Looking down	_____	_____	_____
Looking up	_____	_____	_____
Turning head	_____	_____	_____
Lifting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Nighttime	_____	_____	_____
Morning	_____	_____	_____

Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing,
piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____

Does the symptom **radiate (travel)** to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please circle)
No difference Morning Afternoon
Evening Night Other _____

Patient Name_____ **Date:** _____ **Iowa Chiropractic and Performance Center – Dr. Conrad Stalheim**
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NEW PATIENT HISTORY FORM

Symptom 3 _____

What level would you rate your pain MOST OF THE TIME? (circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

What ***percentage*** of the time **you are awake** do you experience the above symptom at the above intensity:

10 20 30 40 50 60 70 80 90 100 %

Did the symptom begin **suddenly** or **gradually**? (circle one)

When did the symptom begin? _____
How did the symptom begin? _____
_____

Over the past **MONTH** has your pain…
__Improved __Worsened __Not changed
Over the past **WEEK** has your pain…
__Improved __Worsened __Not Changed

Prior tests for your pain:
X-ray_____
MRI_____
CT_____
Lab_____
Other_____

Prior treatment for your current problem:
Anti-Inflammatory (NSAIDs): __Ibuprofen __Aleve __Celebrex __Mobic
Other_____ Results: _____
Steroids: __Prednisone pills __Cortisone injection
Other _____ Results: _____
Injections:__Epidural __Facet __Other Results:_____
Spinal surgery: Year/Procedures/Results_____
Physical Therapy: Year/Procedures/Results_____
Chiropractic: Year/Procedures/Results_____
Other Treatments: Year/Type/Results_____

How do the following affect your pain?

	No change	Worse	Better
Cough/sneeze	_____	_____	_____
Sitting	_____	_____	_____
Sit to Stand	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Lying on stomach	_____	_____	_____
Looking down	_____	_____	_____
Looking up	_____	_____	_____
Turning head	_____	_____	_____
Lifting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Nighttime	_____	_____	_____
Morning	_____	_____	_____

Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing,
piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____

Does the symptom **radiate (travel)** to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please circle)
No difference Morning Afternoon
Evening Night Other _____

**If you have additional symptoms – please print this page for each additional symptom.*