NEW CLIENT PAPERWORK

CLIENT NAME: ____ DOB:______________________

Client Information

Today's Date ____________________

Address ____

Street City State Zip

Primary Phone #_____________________________ Secondary #___________________________________

E-mail ____

Age _______ Gender: ❍ Male ❍ Female ❍ Other Primary Doctor: ________________________________

How did you hear about us? ____

(Like us on Facebook to obtain nuggets of health info regularly, and leave a review on Google/Facebook if you love your care!)

Emergency Contact Info:

Name__________________________________ Relationship______________________________

Phone_________________________________

If Over 18:

Occupation________________________________

Employer____________________________ NA: ____

Marital Status: ❍Single ❍ Married ❍Divorced

Spouse's Name____________________________

Spouse's Birth-date__________________________

Under 18

Parent Name ____________________________

Parent Name ____________________________

Signature of Guardian:

____

Person Financially Responsible for Account

❍ Self (if chose "self" skip to bottom signature)

Name ____________________________________

Relationship _______________ B-day____________

Address ❍ Same as Above

____

Street

____

City State Zip

Responsible Party's Signature

____

CLIENT NAME: ____ DOB:____________________

nourish Family Wellness

CLIENT NAME: ______________________________ DOB:______________

Care Information

Reason for Care:____

____

____

What do you want to see change?

____

____

How will this change your life if you achieve it?

____

____

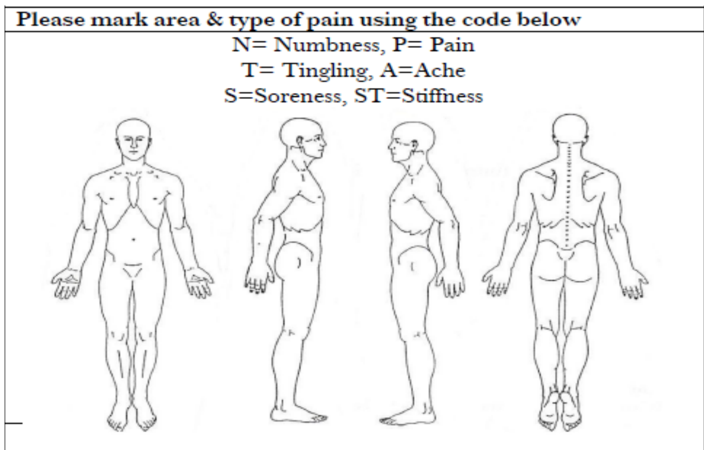
____

____

Do you (and your family) want to be healthier?

❍ Yes ❍ No

If you are experiencing discomfort, please fill out the below diagram appropriately:



Condition History

complete this box if seeking care for a condition

When did this condition appear?____

Other providers you've seen for this condition?

❍ No ❍ Yes If yes, who?____

Medications Prescribed & Expected End Date: ____

____

Is current condition due to an injury? ❍ Yes ❍ No

If Accident, Type of Accident? ❍Auto ❍At Work ❍Home ❍N/A ❍Other ______________________

To whom have you made a report of the accident: ❍Auto Insurance ❍Employer ❍Work Comp ❍N/A

Disabilities? ❍ No ❍ Yes If yes, when and how?____

New Client Paperwork

Client Name: ____ DOB:____________________

What is your: height:___________ weight:______________

Exercise Level: ❍ None ❍ Minimal ❍ Moderate ❍ Strenuous ____ times/week Type:____________________

Regular Habits: ❍ Smoking ____Packs/Day ❍Alcohol _____Drinks/Week ❍Caffeine _____ Cups/Day

Please circle "past" and/or "now" for each item below that applies to your health history:

		General			**Digestion**			**Eye/Ear/Nose/Throat**			**Respiratory**
Past	Now	Allergy ___________	Past	Now	Belching/Gas	Past	Now	Asthma	Past	Now	Chest Pain/Tightness
Past	Now	Chills	Past	Now	Colon Trouble	Past	Now	Tonsillitis	Past	Now	Chronic Cough
Past	Now	Convulsions	Past	Now	Constipation	Past	Now	Sinusitis	Past	Now	Difficulty Breathing
Past	Now	Dizziness	Past	Now	Diarrhea	Past	Now	Allergies	Past	Now	Wheezing
Past	Now	Fainting	Past	Now	Excessive Hunger	Past	Now	Earache	Past	Now	Spitting Blood
Past	Now	Fatigue	Past	Now	Gallbladder Trouble	Past	Now	Ear Discharge	Past	Now	Phlegm Production
Past	Now	Fever	Past	Now	Hemorrhoids	Past	Now	Ear Noise	Past	Now	Bronchitis
Past	Now	Headaches	Past	Now	Jaundice	Past	Now	Frequent Colds			**Genitourinary**
Past	Now	Loss of Sleep	Past	Now	Liver Trouble	Past	Now	Hay Fever	Past	Now	Bed Wetting
Past	Now	Loss of Weight	Past	Now	Nausea	Past	Now	Hoarseness	Past	Now	Blood in Urine
Past	Now	Nervousness	Past	Now	Pain in Stomach	Past	Now	Nasal Congestion	Past	Now	Frequent Urination
Past	Now	Nerve Pain	Past	Now	Poor Appetite	Past	Now	Nose Bleeding	Past	Now	Urinary Incontinence
Past	Now	Night Sweats	Past	Now	Poor Digestion	Past	Now	Pain in Eyes	Past	Now	Kidney Infection
Past	Now	Numbness (arms, legs or hands)	Past	Now	Vomiting	Past	Now	Poor Vision	Past	Now	Painful Urination
Past	Now	Unconsciousness	Past	Now	Vomiting Blood	Past	Now	Crossed Vision	Past	Now	Prostate Trouble
		Muscles/Joints			**Cardiovascular**			**Skin**			**For Women Only**
Past	Now	Backache	Past	Now	High Blood Pressure	Past	Now	Bruise Easily	Past	Now	Cramps/Backache
Past	Now	Pain Between Shoulder Blades	Past	Now	Low Blood Pressure	Past	Now	Dryness	Past	Now	Excessive Flow
Past	Now	Stiff Neck	Past	Now	Pain over Heart	Past	Now	Eczema	Past	Now	Hot Flashes
Past	Now	Swollen Joints	Past	Now	Poor Circulation	Past	Now	Hives	Past	Now	Irregular Cycle
Past	Now	Foot Trouble	Past	Now	Heart Trouble	Past	Now	Itching	Past	Now	Miscarriage
Past	Now	Painful Tailbone	Past	Now	Rapid Heart Rate	Past	Now	Sensitive Skin	Past	Now	Painful Periods
Past	Now	Spinal Curvature	Past	Now	Slow Heart Rate	Past	Now	Skin Eruptions	Past	Now	Vaginal Discharge/Odor
Past	Now	Tremors	Past	Now	Stroke	Past	Now	Boils	Past	Now	Birth Control Medication
Past	Now	Twitching	Past	Now	Swollen Ankles				Past	Now	IUD
Past	Now	Weakness	Past	Now	Varicose Veins	Past	Now	Hormone Replacement	Past	Now	Last Pap Exam?_______
Past	Now	Arthritis	Past	Now	Anemia				Past	Now	Pregnancy
Past	Now	Jaw Pain							Guess date		________________

Have you had any of the following diseases? (circle all that apply)

Diabetes Cancer Hepatitis Tuberculosis Pneumonia Venereal Disease

Alcoholism Lupus Measles Goiter Epilepsy Polio Rheumatic Fever

Chicken Pox Pleurisy Mental Disorder Rheumatoid Arthritis Whooping Cough

Operations & Procedures:

Date(s)		Date(s)		Date(s)		Date(s)	
__________	Tonsillectomy	__________	Gall Bladder	__________	Back Surgery	__________	Hernia
__________	Vaccinations	__________	Tubes in Ears	__________	Female Organs	__________	Thyroid
__________	Appendectomy	__________	Stomach	__________	Cesarean	__________	Other

Family History- Describe on the line provided below

❍ Diabetes ❍ Heart Problems ❍ Kidney ❍ Cancer ❍ Autoimmune Disease ❍ Other_____________

__________ _________________ ___________ ___________ __________________ ______________

Are you currently taking any medications/supplements/herbs? (please list and for what condition)

____

New Client Paperwork

CLIENT NAME: ____ DOB:_________________

Please read thoroughly, initial at each applicable section and sign at the bottom. Thank You

Personal Information

__________ I understand that my information may be used for internal marketing purposes (newsletters, emails, etc.). Personal information will not be shared with any other company for marketing purposes.

Information about Possible Risk of Chiropractic Treatment

__________ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

___________ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

NON-HIPAA Communications

__________ I understand that when I contact the office through social media or email, I am waiving my HIPAA rights as there can be no guarantee that my information can maintain confidential status through these routes of communication. Despite, I understand the convenience and if I do contact Nourish Family Wellness PLLC through these avenues, I would like a reply.

Guarantee of Payment

__________ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility, despite insurance promised coverage.

Cancelation Policy

__________ I am aware that there is a 24 hour cancelation policy and if I cancel within the 24 hour period, I may be charged a partial cancellation fee up to the amount of my visit.

____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

Authorization to Treat a Minor (under the age of 18)

___________I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Nourish Family Wellness, PLLC.

____

Signature of Patient or Responsible Party Date Relationship to Patient

____

Signature of Doctor Date

PRINTED NAME____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Or Patient Representative)
PATIENT SIGNATURE:____________________________________Date________________

Nourish Family Wellness
525 Main Street, #200
New Brighton, MN 55112

P (651) 797-4822
F (651) 796-0209
frontdesk@nourishfamilywellness.com

CLIENT NAME: ______________________________ DOB:______________

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Nourish Family Wellness, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

______________________________ ______________
Patient or Legally Authorized Individual Signature Date

______________________________ ______________
Print Patient's Full Name Time

______________________________ ______________
Witness Signature Date

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information