SANDS CHIROPRACTIC
Central Iowa Wellness Center

Welcome to Central Iowa Wellness Center

At Central Iowa Wellness Center it is our mission to help you achieve all of your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess this and to understand the root cause of your symptoms, we will be taking you through a series of non-invasive examinations on your initial visit. This will include a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, and blood pressure.

On the day of your visit we ask that you wear clothing that you are comfortable moving in for the physical portion of the examination. We will be taking a postural photo of you so please don't wear bulky clothing or multiple layers. In addition to this, if you have any previous X-ray or MRI reports please bring these along on this visit for our records if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take about 45 minutes so we ask that you allow sufficient time and if you have any concerns please speak to our receptionist before your visit if time is a constraint.

PLEASE NOTE:
If you are running late, you do run the risk of our Doctor or massage therapist being unable to see you. If this is the case, please contact our reception staff at (515) 984-6484 and we will try to accommodate your needs.

We ask for 24 hour cancellation notice for massage but understand that emergencies do occur. If you miss two massage appointments in a calendar year you will be billed 100% for the second occurrence and full price for any subsequent cancellations.

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Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Name_____Today's Date_____Birthdate_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone _____

Gender •M •F Age ___

Kid's Names & Ages_____

Your Employer_____Type of Work_____

e-Mail Address _____

Have you been to a chiropractor before? □ No □ Yes

Emergency Contact_____(Relationship)_____Phone #_____

• I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.

• I authorize the doctor or staff to perform any necessary examination procedures.

• I authorize Sands Clinic to release and / or request records to or from other providers as may be necessary.

• I understand I am responsible for all bills incurred in this office. I understand the clinic privacy policy.

• I authorize assignment of my insurance benefits (if applicable) directly to the provider.

• Person responsible for this account if other than the patient_____

• I understand that after any initial promotional services all care is rendered at usual and customary fees.

• I authorize Sands Clinic to use my email and phone number/text for patient and clinic communication purposes.

• For my balance my preferred payment method is: •Cash •Check •Credit Card •Car/Work Ins.

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

_____ _____
Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

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Financial Responsibility

We provide our services directly to you, not your insurance company. You are ultimately responsible for your bill. If you are submitting your own claims we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered, provided that your deductible, co-insurance, and/or copay for said services have been paid. In the event that we are billing your insurance and a check is mailed to you, you MUST bring the payment to the office within 7 days so that we may properly credit your account. If your insurance carrier has not paid a claim within 90 days of submission, you accept responsibility for payment in full of the outstanding balance. You are required to inform us of any and all insurance changes within 30 days. You will be responsible for any outstanding charges accumulated during your insurance lapse. If your balance reaches $100 and there is no payment plan scheduled, we hold the right to not provide service to you until payment is made or a payment plan is in place. If you discontinue care for any reason, all balances become immediately due and payable in full by you, regardless of any claim(s) submitted. If your account enters into a default status and is considered past due, you assume and agree to pay any administrative fees that may be associated with the collections process. (A default account is deemed when your patient balance is $100 or more or any amount 90 days past due.)

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of above signature Relationship to Patient

Females Only

I hereby give my consent to Central Iowa Wellness Center and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____
Patient/Guardian Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

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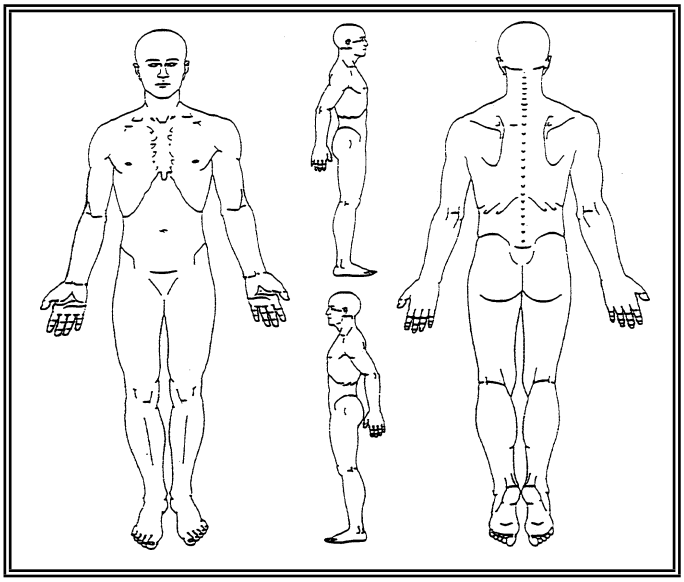
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	//////////	OOOOOOOOO	SSSS S	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs?_____**Is there any numbness or tingling?** _____

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time)_____Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time)_____Intermittent (0 – 25% of the time) _____

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List any MD's or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV
☐None ☐Other _____

What makes your problem worse? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting
☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit To Stand
☐Other_____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life:_____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** _____

List any medications, herbs or supplements you are taking and the REASON for their use:

_____

_____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: _____

Father: ☐Living ☐Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis
☐Scoliosis ☐Thyroid disease ☐Osteoporosis _____

SOCIAL HISTORY

Marital status: ☐Married ☐Single ☐Divorced ☐Common Law ☐Engaged ☐Widowed

Do you have any children? ☐Yes ☐No If yes, how many?ages?_____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

Do you smoke? ☐Yes ☐No If yes, how much, how often & how long? _____

Are you currently employed? ☐Yes ☐No If yes, what is your occupation? _____

Who is your current employer?_____**How long have you been at this job?** _____
What do you do most of the day in your job postures, positions and repetitive movements:_____**-**

_____

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:
Exercise_____Sleep_____Diet_____Stress Level_____Water Intake_____Energy Level_____= _____

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REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____Headaches _____Faintness _____Dizziness _____Insomnia	**Energy/Activity:** _____Fatigue/Sluggishness _____Apapthy/Lethargy _____Hyperactivity _____Restlessness	**Lungs:** _____Chest Congestion _____Asthma, Bronchitis _____Shortness Of Breath _____Difficulty Breathing
Eyes: _____Watery or Itchy Eyes _____Swollen, Red or Sticky Eyelids _____Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____Binge Eating/Drinking _____Craving Certain Foods _____Excessive Weight _____Compulsive Eating _____Water Retention _____Underweight	**Heart:** _____Irregular or Skipped Heartbeat _____Rapid or Pounding Heartbeat _____Chest Pain
Ears: _____Itchy Ears _____Earaches, Ear Infections _____Drainage From Ear _____Ringing In Ears, Hearing Loss	**Emotions:** _____Mood Swings _____Anxiety/Fear/Nervousness _____Anger/Irritability/Aggressiveness _____Depression	**Digestive Tract:** _____Nausea, Vomiting _____Diarrhea _____Constipation _____Bloated Feeling _____Belching, Passing Gas _____Heartburn _____Intestinal/Stomach Pain
Nose: _____Stuffy Nose _____Sinus Problems _____Hay Fever _____Sneezing Attacks _____Excessive Mucus Formation	**Mind:** _____Poor Memory _____Confusion, Poor Comprehension _____Poor Concentration _____Poor Physical Condition _____Difficulty Making Decisions _____Stuttering or Stammering _____Slurred speech	
Mouth & Throat: _____Chronic Coughing _____Frequent Need to Clear Throat _____Sore Throat, Hoarseness _____Swollen or Discolored Tongue _____Canker Sores		**Other:** _____Frequent Illness _____Frequent or Urgent Urination _____Genital Itch or Discharge
Skin: _____Acne _____Hives, Rashes, Dry Skin _____Hair Loss _____Flushing, Hot Flashes _____Excessive Sweating	**Joints/Muscles:** _____Pain or Aches in Joints _____Arthritis _____Stiffness or Limited Movement _____Pain or Aches in Muscles _____Weakness or Fatigued Muscles	**Grand Total:**

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____