Chiropractic Offices of Gonstead, Stangl & Arkowski, LLCs

☐ Dr. MJ Gonstead ☐ Dr. Melissa Stangl ☐ Dr. Lisa Arkowski ☐ Dr. Jennifer Gonstead

503 E. Clairemont Avenue ◆ Eau Claire, WI 54701 ◆ 715-832-2223

Date:

NEW PATIENT INTAKE			
Name (first) (M) (Last)			
Address	**City**	**State**	**Zip**
Phone (Home) (Cell) (Work)			
Date of Birth	**Age**	**Gender** ☐ Male ☐ Female	
Email Address			
Race ☐ Caucasian/White ☐ African American/Black ☐ Asian ☐ Native American ☐ Other			
Ethnicity ☐ Hispanic/Latino ☐ NOT Hispanic/Latino			
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed			
Spouse's Name			
Children ☐ YES ☐ NO name(s)			
Employer	**Occupation**		
Emergency Contact	**Phone**	**Relationship**	
How did you hear about our office? ☐ insurance ☐ medical provider ☐ website ☐ Facebook ☐ ad/event ☐ family/friend:			

SOCIAL HISTORY
Smoking Status ☐ Never Smoker ☐ Daily Smoker ☐ Occasional Smoker ☐ Former Smoker – quit date:
Do you use non-smoking tobacco products? ☐ NO ☐ YES
Alcohol Status ☐ None ☐ Casual ☐ Moderate ☐ Heavy ☐ Beer ☐ Wine ☐ Liquor
Caffeine Status ☐ None ☐ less than 3 drinks/day ☐ 3-6 drinks/day ☐ more than 6 drinks/day
Exercise ☐ Never ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims ☐ Weights ☐ Other:

FAMILY HISTORY - ☑ where applicable					
CONDITION	**SELF**	**FATHER**	**MOTHER**	**SIBLING**	**GRANDPARENT**
Aneurysm					
Cancer/Tumor					
Diabetes					
Epilepsy/Seizure					
Heart Disease					
High Cholesterol					
Hypertension					
Multiple Sclerosis					
Osteopenia/porosis					
Stroke					

PATIENT HISTORY				
DATE	**SURGERY - HOSPITALIZATIONS**		**DATE**	**ACCIDENT - ILLNESS - INJURY**

Patient Initials _____

PATIENT NAME	DATE

Previous Chiropractic Care ☐ NO ☐ YES Approximate Last Appointment:
Previous Doctor of Chiropractic Name/Location:

Current Health Care Provider(s)	Location(s)
Do you grant permission to contact these providers? ☐ NO ☐ YES Please initial here →	

Have you had radiology imaging within the past 2 years? ☐ NO ☐ YES		
☐ X-RAY	Region:	Date/Location:
☐ MRI ☐ CT	Region:	Date/Location:
☐ OTHER	Region:	Date/Location:

CURRENT MEDICATIONS (Rx or OTC), VITAMINS, HERBS AND SUPPLEMENTS					
STARTED	NAME	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBED BY

ALLERGIES AND SENSITIVITIES	REACTION

REVIEW OF SYSTEMS – Please circle C = current P = Past

GENERAL			**CARDIOVASCULAR**			**GASTROINTESTINAL**			**ENT**		
C	P	Weight Gain	C	P	Chest Pain	C	P	Abdominal Pain	C	P	Cold/Congested
C	P	Weight Loss	C	P	Heart Murmur	C	P	Abnormal Stool	C	P	Dizzy/Vertigo
SKIN/BREAST			C	P	Hypertension	C	P	Appetite ⇧⇩	C	P	Headache/Migraine
C	P	Breast lump/tender	C	P	Palpations	C	P	Change in bowel	C	P	Nosebleeds
C	P	Dry Skin/Texture	C	P	Sleep Apnea	C	P	Constipation	C	P	Throat tender/mass
C	P	Nail Changes	C	P	Shortness of breath	C	P	Diarrhea	C	P	Vision changes
C	P	Mole Changes	C	P	Syncope (fainting)	C	P	Heartburn	**PSYCHIATRIC**		
C	P	Rash/Itching	C	P	Varicosities	C	P	Hemorrhoids	C	P	ADD/ADHD
NEUROLOGIC			**RESPIRATORY**			C	P	Indigestion	C	P	Anxiety
C	P	Convulsions	C	P	Asthma	C	P	Nausea/Vomit	C	P	Depression
C	P	Incoordination	C	P	Cough	**GENITOURINARY**			C	P	Bipolar
C	P	Memory	C	P	COPD	C	P	Bed Wetting	**IMMUNE/LYMPH/ENDOCRINE**		
C	P	Neuropathy	C	P	Fever/night sweats	C	P	Bleeding/Discharge	C	P	Anemia
C	P	Numbness	C	P	Infections	C	P	Cycle Irregularities	C	P	Bleeding Issues
C	P	Paralysis	C	P	Pain/Wheezing	C	P	Difficulty urinating	C	P	Lymph node large/tender
C	P	Speech	C	P	Shortness of breath	C	P	Libido	C	P	Frequent thirst/hunger
C	P	Tingling	C	P	Pneumonia	C	P	Pain on Urination	C	P	Heat/cold intolerant
C	P	Tremors				C	P	Unusual color/smell Urine	C	P	Thyroid Issues
						C	P	Urgency/Frequency			

FEMALES	Are you currently pregnant ☐ NO ☐ YES Due Date:	History of previous miscarriage? ☐ NO ☐ YES
Menopause ☐NO ☐YES	Current PAP ☐NO ☐YES	Current Mammogram ☐NO ☐YES Regular self-breast exams ☐ NO ☐ YES

Patient Initials _____

PATIENT NAME	DATE

HISTORY OF PRESENT COMPLAINT
Are your present complaints due to any of the following: ☐ Auto Accident ☐ Work Injury ☐ Personal Injury ☐ No
Have you had any recent accidents, falls, or injuries? ☐ No ☐ Yes approximate date:
Have you had any recent hospitalizations or new diagnoses? ☐ No ☐ Yes
Have you had any recent major life events? ☐ No ☐ Yes

NECK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

HEADACHE/MIGRAINE ☐ No Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Describe location AND quality of symptoms:	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Daily ☐ Weekly ☐ Monthly ☐ Constant (75-100%)	

MIDBACK ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	

LOW BACK/HIP/PELVIS ☐ No Current Complaint	
Describe Current Complaint	
Date of Onset:	☐ Acute ☐ Chronic ☐ Recurrent ☐ Sudden ☐ Gradual
Provocation (what caused/contributed):	
Quality: ☐Ache ☐ Burn ☐ Dull ☐ Pinch/Stab ☐ Sharp ☐ Sore ☐ Spasm ☐ Stiff ☐ Throb ☐ Tight ☐ Other	
Radiation: ☐ Stay Localized ☐ Pain Travels/Shoots ☐ Pain Extends elsewhere ☐Numbness ☐ Tingling	
Severity: ☐ Minimal (no impairment) ☐ Slight (some impairment) ☐ Moderate (ADLs difficult) ☐ Marked (preclude activity)	
Pain Level: (no pain) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (worst pain ever, nothing else matters)	
Timing: ☐ Intermittent (0-25%) ☐ Occasional (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)	
What Makes it better?	
What Makes it worse?	
Check if you experience ☐ Upper extremity complaints ☐ Lower Extremity complaints ☐ Other Complaints:	

Patient Signature _____ Date _____

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503 E. Clairemont Ave ♦ Eau Claire, WI 54701 ♦ (715) 832-2223

INSURANCE INFORMATION

A ☐ Check this box if you are NOT billing insurance for your chiropractic services (Proceed to Section B)

Patient Name		Date of Birth
Patient Address		Patient Phone Number
City	State	Zip Code
Patient's Employer		Employer Phone
Insurance Company		Are you the primary Insurance Holder? Y N
If you're not the primary insurance holder, who is? (Check below)		
☐ Spouse ☐ Mother ☐ Father ☐ Other		
Policy #		Group #

Please fill out the information below if you are not the primary insurance holder		
Name of Primary		Primary's DOB
Primary's Address		Primary's Phone #
City	State	Zip Code
Primary's Employer		Employer's Phone #

Do you have secondary insurance? ☐ Yes ☐ No	
Policy #	Group #

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits for any reason, I understand that I am responsible for all remaining charges.

Patient Signature _____ Date _____

B By signing below, I do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures my consist of manipulations/ adjustments involving movement of the joints and soft tissues. Physical therapy exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness, Dizziness, Fractures/joint injury, Stroke, and physical therapy burns.

I understand the probability of any of these risks occuring is rare and that tests will be performed on me to minimize the risk of any complication from treatment, and I freely assume these risks. I am aware that reasonable alternatives to chiropractic procedures are available to me including rest, home application of therapy, prescription and over the counter medications, exercises, and possibly surgery. I also understand that there are beneficial effects associated with chiropractic treatment procedures including decreased pain, improved mocbility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person(s) of the doctor's choosing. **I have read or have had read to me the above explanations of chiropractic treatment. Any question I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decisions voluntarily and freely.**

Patient Signature _____ Date_____

Office staff use only: Copy of Patient's insurance card is on file ☐ Staff Initials

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information (PHI). There are several circumstances in which we may have to disclose your health care information.

• We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

• We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

• We may need to use your health information within our practice for quality control or other operational purposes.

• We may need to use your personal health information such as name, address, email or phone number to contact you with appointment reminders.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocations must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice, if I request it.

_____ _____

Print Patient Name Authorized Staff Representative

_____ _____

Patient or Parent's Signature Date

I WOULD LIKE A COPY OF THIS HIPAA POLICY? YES NO (CIRCLE ONE) *PAPER COPY EMAIL* (CIRCLE ONE)

503 E CLAIREMONT AVENUE * EAU CLAIRE, WI 54701 * PHONE: 715-832-2223 * FAX: 715-832-7416

Patient name: _____ DOB: _____

AUTHORIZATION FOR VERBAL COMMUNICATION

👉**Whom may we speak to on your behalf about scheduling and/or billing**

(List First and Last Names of Person(s) To Whom Your Information May Be Disclosed, Such as Parents, Spouse, Etc).

I authorize communication between :_____

_____

And the doctor(s)/staff of:

O MJ Gonstead LLC
O Arkowski Chiropractic LLC
O Stangl Chiropractic & Massage Therapy LLC
O Jennifer Gonstead Chiropractic LLC

AUTHORIZATION TO LEAVE VOICEMAIL/TEXT MESSAGES

👉**May we leave a voicemail or text about scheduling and/or billing**

O Leave Voicemail/Text at the Following Number(s)_____

Cell Phone provider: O Verizon O T-Mobile O AT&T O _____ (Other)

I authorize to leave messages with:

O Anyone O Names of authorized individuals listed above

👉This authorization will expire **one year** from date signed, unless otherwise indicated:

O Indefinite O Other end date: _____ (MM/DD/YYYY)

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information pertaining to appointments and billing at this office. This does not authorize the release of copies of medical records.

Signature of Patient/Representative: _____

Date: _____

If signed by persons other than the patient, please print name and state relationship to patient.

Print Name: _____*Relationship:* _____