Galloway Wellness New Patient Intake File #: _____

How were you referred: _____

Patient Name: _____ Date: _____

Gender: M / F / Other Age: _____ Date of Birth: _____/_____/_____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Blood Type: A / AB / B / O Rh: + / -

Marital Status: _____ Occupation: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Health Conditions and Complaints: (list in order of severity)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Purpose of Appointment: (What are you hoping to gain from this experience?)

Allergies:

Current Medications and Supplements:

Name	Dosage	Frequency	Duration

Last Physical: _____ Results: _____

Last Lab Test: _____ Results: _____

Women: Date of Last PAP Smear: _____ Results: _____ Pregnant: Yes / No / Maybe

Men: Date of Last PSA/Prostate Test: _____ Results: _____

Medical Procedures, Hospitalizations, Injuries, Serious Illness:

Date	Procedure/Surgery/Illness	Outcome	Physician

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Galloway Wellness New Patient Intake File #: _____

Lifestyle and Health Overview:

Do you follow any specific plan of eating? Y/ N If yes, which: _____

How many times a day do you eat? _____ How often do you eat out? Daily _____ Weekly _____

Digestion: Good / Adequate / Poor Symptoms: Acid Reflux / Burping / Bloating / Burning / Pain / Cramping / NA

Bowels Movements: Daily _____ Weekly: _____ Consistency: Normal / Hard / Soft / Diarrhea

Urination: Normal / Too Frequent / Sense of Urgency / Burning / Dribbling / Loss of Control / Wake at Night

Additional Complaints: _____

How much water do you drink daily? _____

Mark which you drink and how many a day (d) or week(w) you drink them:

Milk: _____ Herbal Tea: _____ Wine: _____

Coffee: _____ Soda: _____ Liquor: _____

Tea: _____ Beer: _____ Other: _____

Sleep: Restful / Restless / Hard to fall asleep / Wake Often / Wake to urinate / Nightmares / Night Terrors

What time do you go to sleep? _____ Number of hours of sleep per night? _____

Stress level 1 – 10 (10 being greatest): _____ Main Stressors: _____

How do you reduce stress? _____

Do you smoke? Y / N If yes, how many cigarettes and often? _____ How long have you smoked? _____

Drug Use (CONFIDENTIAL):

Recreational Drug Use: Y/N If yes: Marijuana / Cocaine / Heroin / Uppers / Downers / Other: _____

How often? _____ How long? _____

Women Only

Menstrual Cycle: Are you in menopause? Y / N If yes, are you still spotting or menstruating? Y / N

Do you have monthly periods? Y / N Date of Last Period: _____ Cycle Length: _____

Flow: Normal / Spotting / Light / Heavy Symptoms: Cramps / Bloating / Weak / Mood Swings / Cravings / Pain / Clotting

Are you currently pregnant? Y / N Trying to conceive? Y / N Total number of pregnancies: _____

How many live births? _____ Are you breastfeeding? Y / N

Remember to list any supplements or medications on the first page.

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Galloway Wellness New Patient Intake File #: _____

Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 30 days.

0=Rarely/never experience the symptom **1**=Occasionally experience but effect is not severe
2=Occasionally experience but effect is severe **3**=Frequently experience and effect is not severe
4=Frequently experience and effect is severe

Digestive:

Gas, Belch, Bloating	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Nausea	0 1 2 3 4
Strain on bowel mvmt	0 1 2 3 4
Day w/o bowel mvmt	0 1 2 3 4
Diarrhea, Vomiting	0 1 2 3 4
Hemerrhoids	0 1 2 3 4

Total for section: _____

Heart:

Shortness of breath	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Chest pain	0 1 2 3 4
Rapid, Skipped heartbeat	0 1 2 3 4
High, Low Blood Pressure	0 1 2 3 4

Total for section: _____

Emotions:

Mood swings	0 1 2 3 4
Anger, Irritability	0 1 2 3 4
Anxious, Fearful, Nervous	0 1 2 3 4
Panic attacks	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Depression	0 1 2 3 4

Total for section: _____

Energy:

Restlessness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Brain fog	0 1 2 3 4
Sluggishness	0 1 2 3 4
Fatigue, Tired	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4

Total for section: _____

Skin, Hair, Nails:

Flushing	0 1 2 3 4
Cold hands and feet	0 1 2 3 4
Acne	0 1 2 3 4
Dry skin / Oily skin	0 1 2 3 4
Hives, Rashes	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4
Hair loss	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4
Bruising	0 1 2 3 4
Brittle nails	0 1 2 3 4

Total for section: _____

Hormones:

Oily skin, Acne	0 1 2 3 4
Pain during period	0 1 2 3 4
Breast tenderness	0 1 2 3 4
Irregular Cycle	0 1 2 3 4
Weight Gain	0 1 2 3 4
Cry easily	0 1 2 3 4
Vaginal dryness	0 1 2 3 4
Hot flashes	0 1 2 3 4
Loss of sex drive	0 1 2 3 4
Erectile dysfunction	0 1 2 3 4
Balding	0 1 2 3 4
Anger easily	0 1 2 3 4

Total for section: _____

Head, Eyes:

Blurred vision	0 1 2 3 4
Pressure head/eyes	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Headaches	0 1 2 3 4

Total for section: _____

Allergies:

Watery, Itchy Eyes	0 1 2 3 4
Runny nose	0 1 2 3 4
Sneezing	0 1 2 3 4
Itchy throat	0 1 2 3 4
Itchy skin	0 1 2 3 4
Post nasal drip	0 1 2 3 4

Total for section: _____

Immune:

Frequent illness	0 1 2 3 4
Sore throat	0 1 2 3 4
Fever	0 1 2 3 4
Genital itch, Discharge	0 1 2 3 4
Yellow nail fungus	0 1 2 3 4

Total for section: _____

Urinary Tract:

Frequent urination	0 1 2 3 4
Burning on urination	0 1 2 3 4
Dribbling urine	0 1 2 3 4
Leaky bladder	0 1 2 3 4
Blood in urine	0 1 2 3 4
Kidney stones	0 1 2 3 4

Total for section: _____

Ears, Sinus, Nose:

Popping ears	0 1 2 3 4
Fluid in ears	0 1 2 3 4
Ringing ear, Hearing loss	0 1 2 3 4
Earaches, Infections	0 1 2 3 4
Excessive mucous	0 1 2 3 4
Stuffy Nose	0 1 2 3 4
Sinus Headache	0 1 2 3 4
Nose bleeds	0 1 2 3 4

Total for section: _____

Mouth, Throat, Teeth:

Dry mouth	0 1 2 3 4
Canker sores	0 1 2 3 4
Tooth pain	0 1 2 3 4
Bleeding gums	0 1 2 3 4
Gagging, Clearing throat	0 1 2 3 4

Total for section: _____

Lungs:

Difficulty breathing	0 1 2 3 4
Chest congestion	0 1 2 3 4
Coughing	0 1 2 3 4
Asthma	0 1 2 3 4

Total for section: _____

Joints, Muscle, Bone:

Twitching	0 1 2 3 4
Cramping	0 1 2 3 4
Stiff and achy joints	0 1 2 3 4
Pain in joints	0 1 2 3 4
Muscle ache	0 1 2 3 4
Muscle pain	0 1 2 3 4
Osteoporosis	0 1 2 3 4
Numbness, Burning	0 1 2 3 4
Flat feet, Fallen arch	0 1 2 3 4

Total for section: _____

Sleep:

Inability to fall asleep	0 1 2 3 4
Wake up often	0 1 2 3 4
Nighttime urination	0 1 2 3 4
Wake up tired	0 1 2 3 4
Bad Dreams, Nightmares	0 1 2 3 4
Night sweats	0 1 2 3 4

Total for section: _____

Name: _____ Date: _____ **TOTAL FOR PAGE =** _____

Pain Questionnaire

We realize you may consider that two or more statements in any one section apply but please just circle one number that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment
6. The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

1. I can look after myself normally without causing extra pain
2. I can look after myself normally but it causes extra pain
3. It is painful to look after myself and I am slow and careful
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of self-care
6. I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

1. I can lift heavy weights without extra pain
2. I can lift heavy weights but it gives extra pain
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
5. I can lift very light weights
6. I cannot lift or carry anything at all

Section 4 – Walking*

1. Pain does not prevent me walking any distance
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than 100 yards
5. I can only walk using a stick or crutches
6. I am in bed most of the time

Section 5 – Sitting

1. I can sit in any chair as long as I like
2. I can only sit in my favourite chair as long as I like
3. Pain prevents me sitting more than one hour
4. Pain prevents me from sitting more than 30 minutes
5. Pain prevents me from sitting more than 10 minutes
6. Pain prevents me from sitting at all

Section 6 – Standing

1. I can stand as long as I want without extra pain
2. I can stand as long as I want but it gives me extra pain
3. Pain prevents me from standing for more than 1 hour
4. Pain prevents me from standing for more than 30 minutes
5. Pain prevents me from standing for more than 10 minutes
6. Pain prevents me from standing at all

Section 7 – Sleeping

1. My sleep is never disturbed by pain
2. My sleep is occasionally disturbed by pain
3. Because of pain I have less than 6 hours sleep
4. Because of pain I have less than 4 hours sleep
5. Because of pain I have less than 2 hours sleep
6. Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

1. My sex life is normal and causes no extra pain
2. My sex life is normal but causes some extra pain
3. My sex life is nearly normal but is very painful
4. My sex life is severely restricted by pain
5. My sex life is nearly absent because of pain
6. Pain prevents any sex life at all

Section 9 – Social life

1. My social life is normal and gives me no extra pain
2. My social life is normal but increases the degree of pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
4. Pain has restricted my social life and I do not go out as often
5. Pain has restricted my social life to my home
6. I have no social life because of pain

Section 10 – Travelling

1. I can travel anywhere without pain
2. I can travel anywhere but it gives me extra pain
3. Pain is bad but I manage journeys over two hours
4. Pain restricts me to journeys of less than one hour
5. Pain restricts me to short necessary journeys under 30 minutes
6. Pain prevents me from travelling except to receive treatment.

Total: _____

Financial Policies

METHOD OF PAYMENT:

Payment is due at the time or service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience we accept Credit card, cash, and personal checks.

CHECK RETURN FEE:

There is a $25 charge for checks returned due to insufficient funds.

CANCELLATION/NO SHOW FEE:

While some cancellations are inevitable, cancellations with less than 24-hour notice or missed appointments (no-shows) have unfortunately become a great expense to our organization. If you call with less than 24 hours' notice or if you don't call at all, we reserve the right to bill you for the time we saved for you. No shows, missed appointments or changes in appointments made with less than a 24-hour notice will be charged a $25 fee for chiropractic treatment and $50 for chiropractic examinations, nutritional consults, new patient visits, and massage visits.

INSURANCE:

Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and will collect any copay, co-insurance, or deductible due by you at the time or service. Any non-covered service fees will also be collected at the time of service. If your health plan determines a service to be "**not covered**" or is **not an eligible expense under your plan**. You will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of that statement from your insurance company. It is uncommon, but pre-authorization from your insurance company may be required for chiropractic care in order to receive full benefit coverage. If you are not sure pre-authorization is required for your plan, please contact our office or your insurance company to verify your plan benefits. If required, an authorization must be received by our office prior to your visit. Failure to provide Galloway Chiropractic with proper authorization may result in delay or rescheduling your appointment. You will also be financially responsible for all services related to your visit.

SELF PAY (No Insurance):

We do offer **Cash** patients a 20% discount if balance is paid in full at time of service.

PERSONAL INJURY/AUTO INJURY

Please advise our office on your first visit whenever you have one of the above claims. We will work with any insurance companies/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.
WE **DO NOT** accept *Third Party* Insurance on PI/MVA. You will need to pay cash and we will provide your receipts for you to file.
We also **DO NOT** accept *Worker's Comp.*

MEDICARE:

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes

and files the forms for Medicare at no charge. As a courtesy to you, we will bill your secondary insurance after Medicare pays.

SECONDARY INSURANCES:

Our Office does not file Secondary Insurances.

BALANCES:

Failure to pay any balance due may result in your account being turned over to an outside collection agency. This action will not compromise your care.

I have read and understand the financial policy set forth by Galloway Chiropractic Clinic, LLC, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

Signature of Patient / Legal Representative: _____

Relationship to Patient: _____ **Date**: _____

Insurance Assignment and Authorization:

I hereby direct my insurance company, _____ to pay Galloway Chiropractic Clinic LLC the sum of the proceeds payable under the terms of my insurance policy for dates of services seen in association with Galloway Chiropractic Clinic LLC.

I specifically authorize that this assignment may be paid from disability benefits, medical payments or from any benefits due me under this claim.

I also authorize Galloway Chiropractic Clinic LLC to release any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature: _____ Date: _____

Witness: _____ Date: _____

Fax and E-mail Authorization Form

In order to communicate with you by fax or e-mail, Galloway Chiropractic LLC requires the following information. All information is kept strictly confidential and is used only for our purposes.

Fax Number: _____

E-mail Address: _____

I understand that fax and e-mail communications are not secure forms of communication and that confidentiality of any e-mail or fax cannot be ensured.

I authorize Galloway Chiropractic LLC to Fax and E-mail correspondence, request for information and other documents to me whenever possible.

Printed Name: _____

Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ E-mail: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to Galloway Chiropractic Clinic LLC's use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Persons Authorized to Use or Disclose Information: Information will be used by or disclosed by:

1. Galloway Chiropractic Clinic LLC
2. Name: _____

Who can we release information to / speak to about your care?

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

Authorization and Consent to Treat

The following is provided so that we might have a common understanding of our rights and roles in professional therapeutic relationship. Please read and sign this agreement indicating that you understand and agree to the following. Please ask any questions if you would like further information about any of the following.

1. Information revealed during counseling and treatment sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the legal authorities compel us to do so.
2. Each procedure or treatment carries with it both risks and benefits. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment.
3. Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.
4. Physical examination, chiropractic treatment, and neuro-muscular therapy involves physical contact and may be uncomfortable for some persons. If you are uncomfortable with physical contact or unfamiliar with chiropractic please let the doctor know so that they can assist you and help you find an alternative that is more comfortable for you.
5. You are welcome to bring a friend or relative to your visits if such companionship is comfortable for you.
6. You are encouraged to ask questions on any health-related topic and to take an active role in your health care. This office offers a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain you highest level of health.
7. The doctor may not be available at all times. If you have a serious health problem that requires immediate attention, you should call your other doctors, call 911, or have someone take you to the nearest hospital or emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it and contact the doctor and relate what has occurred as soon as possible.
8. It may become necessary at various times to contact you by phone, mail, or e-mail. By signing this form, you are giving us your permission to contact you by one of the above methods.

The new patient information, health history, and other information that I provided on my intake form are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

Signature of Patient / Legal Representative: _____

Relationship to patient: _____ **Date:** _____

Consent for Minor: I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor assistants of Chiropractic Works to treat my minor child. As of today's date, I have the legal right to select and authorize health care service for the minor child named below. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Print Child's Name: _____

Relationship to Child: _____

Parent/Guardian Print & Sign Name: _____ **Date**: _____