STOIBER
CHIROPRACTIC

Patient Demographics

Name: _____ _____ _____
Last First Middle Initial

Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____

Age: _____ **Gender:** _____ **Date of Birth:** _____ **Pronouns:** _____
(Optional)

Social Security #: _____ (For Insurance Purposes Only)

Referred By: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widow ☐Widower

Email Address: _____

Emergency Contact: _____ Phone: _____

Insurance Information:

Policy Holder Information:

Are you the policy holder? ☐Yes - Please sign and date

☐No - Please fill out policy holder information

Name: _____

Relation to policy holder: Spouse Parent/Guardian

Policy #: _____ **Date of Birth:** _____

Address: _____ _____
Street City

_____ _____
State Zip

Our office is willing to process all insurance claims. We will gladly submit to your insurance **IF** we are given the proper insurance information. Please have us copy your insurance cards and keep us informed and up-to-date with any changes. It is the patient's responsibility to be knowledgeable of their insurance benefits. If you have any questions, you can call the customer service number on the back of your insurance card.

If you have any questions concerning your monthly statement you can call us at 715-424-8000 and ask for the patient accounts department.

I understand that Stoiber Chiropractic will bill my insurance on my behalf. I also understand that any services/ supplies/supplements my insurance does not cover, are my sole responsibility.

Patient/Guardian Signature: _____ Date: _____

Relation To Patient: _____

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Patient History

List all known allergies: _____

What type of regular exercise do you perform: None ○ Light ○ Moderate ○ Strenuous ○

For all of the conditions listed below, please check if you have had the condition in the past or present.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst Frequent
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Blood in Urine
☐	☐	Low Back Pain Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Drug/Alcohol Dependence
			☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Bladder Infection	☐	☐	Depression/Anxiety
☐	☐	Wrist Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain	☐	☐	Abnormal Weight Gain or Loss	☐	☐	HIV/ AIDS
☐	☐	Ankle/Foot Pain				**Females Only:**		
☐	☐	Jaw Pain	☐	☐	Loss of Appetite	☐	☐	Birth Control
☐	☐	Joint Stiffness/Swelling	☐	☐	Abdominal Pain	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Ulcer	☐	☐	PCOS/Endometriosis/POTS
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	General Fatigue	☐	☐	Liver/Gallbladder Disorder	**Please check if an immediate family member has had any of the following:**		
☐	☐	Muscular Incoordination				☐		Rhuematoid Arthritis
☐	☐	Visual Disturbances	☐	☐	Tumor	☐		Heart Problems
☐	☐	Dizziness	☐	☐	Asthma	☐		Diabetes
☐	☐	Numbness	☐	☐	Chronic Sinusitis	☐		Cancer
☐	☐	Thyroid Disorder	☐	☐	Ringing in Ears Cancer	☐		Lupus
☐	☐	Auto Immune Disorder	☐	☐		☐		High Blood Pressure

If yes, What Type? _____

Current Medications: Medication and Dosage:

_____ mg	_____ mg	_____ mg
_____ mg	_____ mg	_____ mg
_____ mg	_____ mg	_____ mg

List all Surgical Procedures, Broken Bones, Fractures, Child Birth:

_____ yr	_____ yr	_____ yr
_____ yr	_____ yr	_____ yr

Do you or have you used any of the following? (check box) If so, How much and how often or when did you stop?

☐ Caffeine	☐ Tobacco	☐ Alcohol
_____ Weekly or Daily	_____ Weekly or Daily	_____ Weekly or Daily
Year _____	Year _____	Year _____

Patient Signature: _____ Date: _____

STOIBER CHIROPRACTIC

Patient Health Questionnaire

Patient Name: _____ **Date:** _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

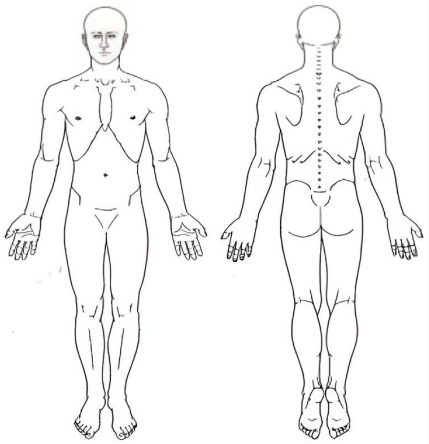
What is your primary area of concern?

_____

If applicable what is your secondary area of concern?

_____

Primary



Indicate where you have pain or other symptoms

2. How often do you experience your symptoms?

	Primary	Secondary
☐ Constantly (76-100% of the day)	☐	☐
☐ Frequently (51-75% of the day)	☐	☐
☐ Occasionally (26-50% of the day)	☐	☐
☐ Intermittently (0-25% of the day)	☐	☐

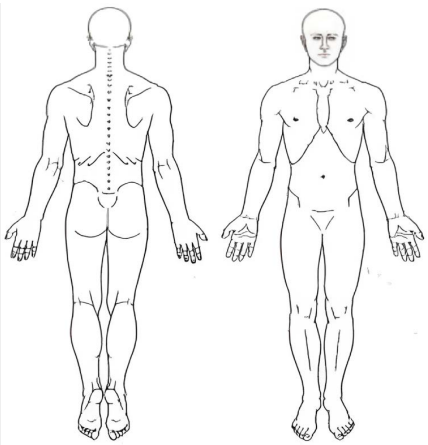
3. What describes the nature of your symptoms?

Primary		Secondary	
☐ Sharp	☐ Shooting	☐ Sharp	☐ Shooting
☐ Dull ache	☐ Burning	☐ Dull ache	☐ Burning
☐ Numb	☐ Tingling	☐ Numb	☐ Tingling

4. How are your symptoms changing?

Primary	Secondary
☐ Getting Better	☐ Getting Better
☐ Not Changing	☐ Not Changing
☐ Getting Worse	☐ Getting Worse

Secondary



5. During the past 4 weeks:

Indicate the average intensity of your symptoms

	None										*Unbearable*
Primary	0	1	2	3	4	5	6	7	8	9	10
Secondary	0	1	2	3	4	5	6	7	8	9	10

6. How much has pain interfered with your life?

(P) (S) Not at all (P) (S) A little bit (P) (S) Moderately (P) (S) Quite a bit (P) (S) Extremely

7. In general would you say your overall health right now is...

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Does anything help relieve your symptoms?

Primary: _____

Secondary: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____

☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other _____

Patient Signature: _____ ***Date:*** _____

Doctor Use:

Height	Weight	CT Initials:
Oxygen %	Heart Rate	BP

STOIBER CHIROPRACTIC

Relieve Pain • Restore Function • Renew Life

Patrick G. Stoiber, DC Lauren M. Stoiber
Victoria A. Zueger, DC

1720 Grove Avenue
Wisconsin Rapids, WI 54494
(p) 715-424-8000 (f) 715-424-8020

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

I hereby acknowledge that I have received a copy of Stoiber Chiropractic's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____, but acknowledgement could not be obtained because:

- ☐ Patient/Representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgment at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

  _____
  _____
  _____
  _____

- ☐ Other (Specifiy)

  _____
  _____
  _____
  _____

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Time of Service Discount

Patient:

A time of service discount may be given when we can eliminate time, paperwork, and postage. Therefore the following pricing applies if no statements and insurance claims need to be generated. This discount only applies if services are paid for the same day they are received, **with no exceptions**. Any services not paid for on the same day will be billed to the patient. If insurance has already been billed, the Time of Service Discount does not apply. **NO EXCEPTIONS.**

Chiropractic Adjustment: $50
New Patient Exam: $70
Established Patient Examination: $40
X-rays: $90 per series
Ultrasound Therapy: $18
Interferential Therapy: $16
Exercise Instruction: $40
Traction: $45
Decompression: $75
Dry Needling: $40
Myofascial: $40

Any patient not seen within the last three years will have to pay for a new patient exam.

I have read and understand the above statement regarding the Time of Service Discount at Stoiber Chiropractic.

Patient Signature: _____

Print name: _____

Date: ____/____/_____