



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: _____



Patient History

STOIBER
CHIROPRACTIC

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

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip/Upper Leg Pain
- Knee/Lower Leg Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Stiffness/Swelling
- Arthritis
- Rheumatoid Arthritis
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness
- Numbness
- Thyroid Disorder
- Auto Immune Disorder

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain or Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gallbladder Disorder
- Tumor
- Asthma
- Chronic Sinusitis
- Ringing in Ears Cancer

If yes, What Type? _____

Past Present

- Diabetes
- Excessive Thirst Frequent Urination
- Blood in Urine
- Drug/Alcohol Dependence
- Allergies
- Depression/Anxiety
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/ AIDS

Females Only:

- Birth Control
- Hormonal Replacement
- PCOS/Endometriosis/POTS
- Pregnancy

Please check if an immediate family member has had any of the following:

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- High Blood Pressure

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:** _____

Patient Health Questionnaire

Patient Name: _____

Date: _____

1. Describe your symptoms _____

What is your primary area of concern?

a. When did your symptoms start? _____

If applicable what is your secondary area of concern?

b. How did your symptoms begin? _____

Indicate where you have pain or other symptoms on the diagrams below

Primary

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)

Secondary

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

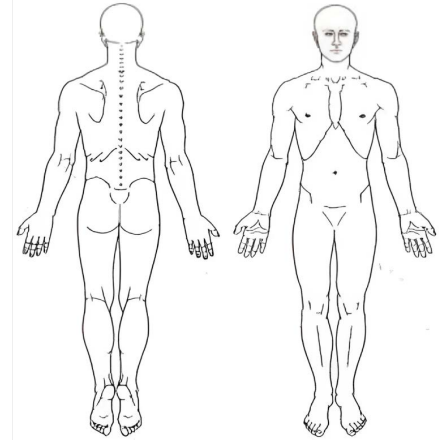
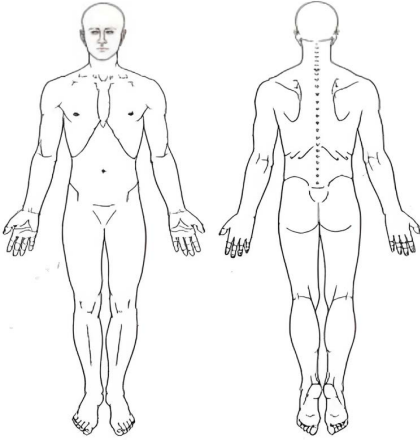
Getting Better

Not Changing

Not Changing

Getting Worse

Getting Worse



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. Does anything help relieve your symptoms?

Primary: _____

Secondary: _____

10. Who have you seen for your symptoms?

No One Medical Doctor Other
Other Chiropractor Physical Therapist

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: _____

11. 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 Medical Doctor Other
Other Chiropractor Physical Therapist

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 (Specify)



STOIBER CHIROPRACTIC

Relieve Pain • Restore Function • Renew Life

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

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: ____ / ____ / ____