CWCI Crossroads Wellness Center

NEW PATIENT APPLICATION

(***Please print in black ink***)

Date:_____ SSN (Only last 4 digits will be used on account): _____

Name:_____ Nickname:_____

Street Address: _____City: _____ State: _____ Zip:_____

E-mail:_____ Contact Phone:_____ ***Is this a mobile number?*** Yes or No ***Can we text you at this number?*** Yes or No Work Phone: _____

Birth Date:_____ Sex: _____ Height: _____Weight: _____

Your Employer: _____ Type of Work: _____

Name & Phone # of Person to Contact in Case of Emergency: _____

Circle If You Are: Married Single Widowed Divorced Separated

Name of Spouse: _____ DOB: _____

Parent/Guardian of Patient (if under age 18)_____

Whom can we thank for referring you?_____

FAMILY HEALTH HISTORY

RELATION	NAME	AGE	PRESENT SYMPTOMS	PREVIOUS SERIOUS ILLNESSES
Father				
Mother				
Siblings				
Children				

Patient Account Number:_____

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HEALTH HISTORY

- **What are your symptoms?**_____
- **Where exactly are your symptoms?**_____
- **When and why did your symptoms begin?**

  _____

  _____

- What activities in your daily life have been disrupted as a result of your symptoms?

  _____

- Please circle if your symptoms are getting worse, staying the same, or getting better.
- What makes your symptoms better?_____
- What makes your symptoms worse? _____
- Do you feel that your weight is contributing to your symptoms in any way? Y / N
  - ☐ Is weight loss a challenge/desire for you? Y / N
  - ☐ Is weight gain a challenge/desire for you? Y / N
- Please circle prior treatments: Chiropractic / Physical Therapy / Massage / Acupuncture / Dry Needling / NSAIDs / Steroids / Injections / Surgery / Other _____
- Besides chiropractic care, please indicate any other therapies/services within our office that you are interested in:
  - ☐ dry needling
  - ☐ functional medicine
  - ☐ naturopathic medicine
  - ☐ kinesio/athletic taping
  - ☐ comprehensive joint assessment
  - ☐ rehabilitation
  - ☐ massage
  - ☐ soft tissue release
  - ☐ cryotherapy
  - ☐ Other _____
- Do you have any additional health concerns/physical limitations that you would like addressed?

  _____

- **What are your overall health/performance goals?**

  _____

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Please answer the following lifestyle related questions.

1. On average, how many hours of sleep do you get per night? _____
2. On average, how many ounces of water do you drink per day?_____
   Filtered? Y / N
3. What do you do on a weekly basis for movement/exercise/fitness?

   _____

   _____
4. What did you eat in the last 24 hours?

   _____

   _____

   a. Was this a typical day of eating for you? Y / N
5. How do you manage stress?

   _____
6. Do you utilize any breathing techniques to manage stress (Y / N) and/or improve sleep/focus/ athletic performance? (Y / N)

   If so, what breathing techniques do you utilize_____
7. Do you have a practice of meditation and/or prayer? Y / N

   a. If so, for how long each day? _____

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PLEASE CHECK APPLICABLE ITEMS – *(indicate date of surgery)*.

OPERATIONS:

Appendectomy _____ Cardiovascular/Heart _____ Female Organs _____

Gall Bladder _____Hernia _____ Rectal _____

Spinal _____ Tonsillectomy _____ Others _____

ACCIDENTS OR FALLS: (Please describe)_____

FRACTURES OR DISLOCATIONS: _____

HABITS: Hobbies_____ Tobacco (How much?)_____
Alcohol_____ drinks per ( ) day ( ) week ( ) month

Coffee (avg. # of cups/day) regular_____ decaf._____ Tea (avg. # of cups/day) regular_____ herbal_____

Soft Drinks (avg. # of 12 oz. cans per day) ( ) regular_____ ( ) diet_____ ( ) caffeine free_____

List all medications and/or supplements you have taken or are currently taking within the past 6 months.

_____
_____
_____
_____

Do you have a history of, or have been treated for any sort of mental disorder? _____

Vaccine History: **Up to date?** Yes or No

Have you received the COVID-19 vaccine? Y / N / NA

- If so, from which company and how many boosters have you received? _____

Have you contracted COVID - 19 in the last 6 months? Y / N

- If so, do you have any long-term symptoms? Y / N _____

CIRCLE Any of the Following Diseases/Conditions you currently have or have had in the past:

ADD / ADHD	Raynaud's Syndrome	Muscular Dystrophy	Goiter
Crohn's Disease	Anemia	Tourette's Syndrome	Padgett's
Herpes	Emphysema	Arthritis	Ulcers
Pleurisy	Infertility	Fibromyalgia	Candida
Alcoholism	Stroke	Osteoporosis	Heart Disease
Diabetes	Anorexia / Bulimia	Trigeminal Neuralgia	Parasites
Hodgkin's Disease	Endometriosis	Bell's Palsy	Venereal Infection
Pneumonia	Multiple Sclerosis	Glaucoma	Chronic Fatigue
Alzheimer's	Thyroid Condition	Parkinson's Disease	Hepatitis
Eczema	Appendicitis	Tuberculosis	Phlebitis
Impotency	Epilepsy	Cancer	

Other: _____

Patient Account Number:_____

Circle current symptoms/Underline past symptoms

GENERAL SYMPTOMS
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Hair Loss
Headache
Hernia
Loss of Sleep
Nervousness
Neuralgia/Nerve Pain
Numbness in arms, hands, or legs
Pain in arms, hands, or legs
Sweats
Tremors
Weak Fingernails
Weight Gain
Weight Loss

E.E.N.T
Allergies
Asthma
Cataracts
Deafness
Dental Decay/Painful Teeth
Ear Discharge
Ear Noises/Ringing
Earache
Enlarged Glands
Enlarged Thyroid
Eye Pain
Failing Vision
Far Sightedness
Frequent Colds
Gum Trouble
Hay Fever
Hoarseness
Macular Degeneration
Nasal Drainage
Nasal Obstruction
Near Sightedness
Nose Bleeds
Sinus Infection
Sore Throat
Tonsillitis

SKIN
Acne
Boils
Bruise Easily
Cysts
Dryness
Hives
Itching
Sensitive Skin
Skin Eruptions
Varicose Veins

RESPIRATORY
Chest Pain
Chronic Cough
Difficult Breathing
Spitting Up Blood
Spitting Up Phlegm
Wheezing

CARDIO-VASCULAR
Cold Hands or Feet
Hardening of Arteries
High Blood Pressure
High Cholesterol
Low Blood Pressure
Pain Over Heart
Paralytic Stroke
Poor Circulation
Rapid Beating Heart
Slow Beating Heart
Swelling of Ankles

MUSCLE & JOINT
Backache
Carpal Tunnel Syndrome
Faulty Posture
Muscle Tightness/Spasm
Pain Between Shoulders
Painful Ankle
Painful Elbow
Painful Foot
Painful Hand
Painful Head
Painful Hip
Painful Knee
Painful Shoulder
Painful Tail Bone
Painful Wrist
Spinal Curvature/Scoliosis
Stiff Neck
Swollen Joints

GASTROINTESTINAL
Belching or Gas
Colitis
Colon Trouble
Constipation
Diarrhea
Difficult Digestion
Distention of Abdomen
Excessive Hunger
Gall Bladder Trouble
Hemorrhoids
Intestinal Worms
Jaundice
Liver Trouble
Nausea
Painful Bowel Movements
Pain Over Stomach
Poor Appetite
Vomiting
Vomiting Blood

GENITOURINARY
Bed Wetting
Frequent Urination
Frequent Kidney or Bladder Infections
Inability to Control Urine
Kidney Stones
Painful Urination
Prostate Trouble
Pus/Blood in Urine

FOR WOMEN ONLY
Cramps
Excessive Flow
Irregular Cycle
Lumps in Breasts
Menopausal Symptoms
Painful Menstrual Periods
Previous Miscarriage
Vaginal Discharge

Are you Pregnant? ( ) Yes ( ) No

Do you think you might be Pregnant? ( ) Yes ( ) No

Patient or Guardian's Signature: _____ Date: _____

Patient Account Number:_____

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HIPAA Privacy Notice

Crossroads Wellness Center strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time, you may request to view or receive a copy of our HIPAA policy. To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA policy has been made available to you upon request.

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are due at the time of service unless prior arrangements have been made. Our office accepts assignment with most insurance companies; however, **INSURANCE IS NOT A GUARANTEE OF PAYMENT**. Your insurance is an agreement between you and your insurance company. All insurance assignment patients must pay their deductibles in full and copayment/ coinsurance at time of service. ***Please be advised that we will not write-off any massage service for any reason by any insurance company, even if we are contracted with your insurance company.*** If our office has not received payment by your insurance company within forty-five (45) days of our office filing the claim, you will become responsible for payment in full.

I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to, the examination, consultation, and/or treatment. I also agree to pay a service charge of $35.00 if my check is returned for insufficient funds. I understand that this service charge may be in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month may be assessed on delinquent balances. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my account.

INFORMED CONSENT FOR CHIROPRACTIC/NATUROPATHIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: Naturopathic medicine, physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic at Crossroads Wellness Center and/or the doctor of Naturopath and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN AFTER YOU AGREE TO THE ABOVE

_____

Printed name of Patient

x_____ Date _____

Signature of Patient

X_____ Date _____

Signature of Representative (if patient is a minor or POA)

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MASSAGE THERAPIST/PATIENT CONTRACT

The relationship between the massage therapist and the patient is one built on trust and mutual respect. To preserve this relationship, the patient should be mindful of our policies before the first session begins.

WHAT PATIENTS CAN EXPECT FROM US:

1. Patients are treated with respect and dignity.
2. Privacy and confidentiality are always maintained.
3. Patients are provided with a competent, professional massage.
4. All patients are draped with a sheet and only the part of the body being worked on is exposed at any time.
5. Our office retains accurate records and review them before each session.
6. All massage therapy is under the direction and supervision of Dr. Caleb Suciu.
7. Our office maintains all massage therapy equipment and supplies to be safe and clean.
8. Our office performs services within the scope of our practice.
9. Our office charges per unit (15 minutes) for massage therapy performed under the direction of the doctor.
10. Our office will bill your insurance with the appropriate service code and diagnosis. If your insurance company allows the billed code it will be applied to your deductible and/or copay. **PLEASE NOTE: INSURANCE IS NOT A GUARANTEE OF PAYMENT**. ***Please be advised that we will not write-off any massage service for any reason by any insurance company, even if we are contracted with your insurance company.***

OUR REQUIREMENTS OF PATIENTS:

1. Massage sessions begin and end at scheduled times. Massages that begin late due to the patient arriving late, end at the appointed time and are charged for the full session.
2. Payment is due at time of service unless prior arrangements have been made with the front office.
3. If cancellation is necessary, please provide our office with at least a 12-hour notice. Otherwise, you will be charged for the appointment unless it can be filled.
4. Patients must provide our office with updated information as necessary on medical history, address, phone number, and insurance.
5. Parents or guardians must be present for massages of minors.
6. Our office will call your insurance company to receive your massage benefits. Customer service may state that these services are covered under your plan. However, please be advised that your insurance company also informs us that insurance is not a guarantee of payment. Therefore, you are ultimately responsible for all services provided by our office.
7. Sexual harassment is not tolerated. If the massage therapist feels their safety is compromised, the session stops immediately, and you will be dismissed as a patient.
8. Please be aware that the use of essential oils may be used during your massage. Please let your therapist know if you object to the use of essential oils.

I have read and agree to the above terms and consent to massage as explained to me.

_____
Printed name of Patient

x_____ Date _____
Signature of Patient

X_____ Date _____
Signature of Representative (if patient is a minor or POA)

Patient Account Number:_____

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