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 Work Phone: _____

Your Employer: _____ Type of Work: _____

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

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

Check If You Are: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Name of Spouse: _____ DOB: _____

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

Whom may 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 because of your symptoms?

  _____
- Select if your symptoms are ◯ Getting Worse ◯ Staying the Same ◯ 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? ◯ Yes or ◯ No
  - Is Weight Gain a challenge/desire for you? ◯ Yes or ◯ No
  - Is Weight Loss a challenge/desire for you? ◯ Yes or ◯ No
- Select Prior Treatments:

☐ Chiropractic	☐ Dry Needling	☐ Surgery
☐ Physical Therapy	☐ NSAIDs	☐ Other _____
☐ Massage	☐ Steroids	
☐ Acupuncture	☐ Injections	

- Please indicate any other therapies/services within our office that you are interested in:

☐ Chiropractic	☐ Kinesio/Athletic Taping	☐ Soft Tissue Release
☐ Naturopathic Medicine	☐ Comprehensive Joint Assessment	☐ Cryotherapy
☐ Functional Medicine	☐ Rehabilitation	☐ Thermography
☐ Dry Needling	☐ Massage	☐ Cupping
☐ Acupuncture		☐ Red Light Therapy
		☐ Hydrotherapy

- 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 CHECK APPLICABLE ITEMS – *(indicate year 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: ◯ Yes or ◯ No How Much? _____

Alcohol: ◯ Yes or ◯ No _____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.

_____

_____

_____

_____

Vaccine History: **Up to date:** ◯ Yes ◯ No ◯ Unvaccinated Covid19 Vaccine? ◯ Yes From_____ ◯ No

Have you been treated for a mental disorder or nervous breakdown? _____

✓ Check any of the Following Diseases/Conditions you currently have or have had in the past:

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

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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? ◯ Yes or ◯ No
3. What do you do on a weekly basis for movement/exercise/fitness?

   _____

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

   _____

   _____

   Was this a typical day of eating for you? ◯ Yes or ◯ No
5. How do you manage stress?

   _____
6. Do you utilize any breathing techniques to manage stress ◯ Yes or ◯ No

   Do you utilize any of these techniques to improve sleep/focus/athletic performance? ◯ Yes or ◯ No

   If so, what breathing techniques do you utilize_____
7. Do you have a practice of meditation and/or prayer? ◯ Yes or ◯ No

   If so, for how long each day? _____

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Check All of the Symptoms you have now:

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 or ◯ No

Do you think you might be Pregnant?
◯ Yes or ◯ No

Patient or Guardian's Signature: _____ Date: _____

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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 TREATMENT AT CROSSROADS WELLNESS CENTER

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: Functional medicine, physical examination, tests, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic at Crossroads Wellness Center 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)

Patient Account Number: _____

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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.

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)

Patient Account Number: _____

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