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NEW PATIENT PACKET

PERSONAL INFORMATION

Full Name

Preferred Name **Gender** Male Female

Address

Phone Number **Date of Birth**

EMail

Status Single Married Divorced Others

Occupation

Primary Care Physician Name:

Referred By:

WHAT GOALS CAN WE HELP YOU ACHIEVE?

GOAL #1

GOAL #2

GOAL #3

EMERGENCY CONTACT DETAILS

Contact Name

Phone Number

Relationship

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REASON FOR VISIT

Reason for Visit?

What Caused Complaint?

When Did Complaint Begin?

Complaint Getting Worse?

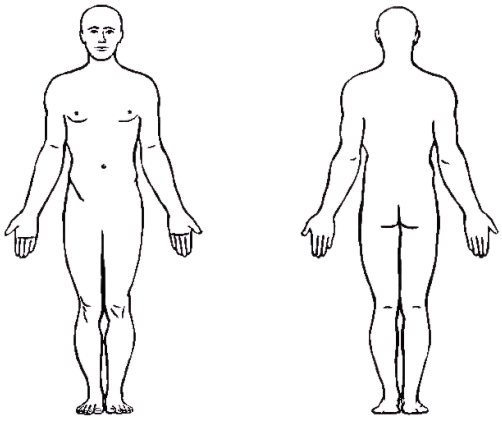
☐ **YES** ☐ **NO** ☐ **CONSTANT** ☐ **COMES & GOES**

What Describes Your Complaint?

Sharp /Dull/ Sore/ Stiff/ Tight/ Aching/ Spams/ Throbbing/ Stabbing/ Shooting/ Burning/ Cramping/ Nagging /Tingling/ Numb

Other

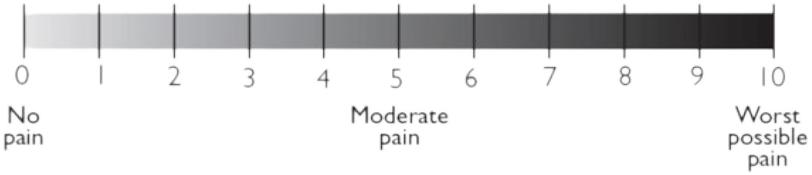
INDICATE ON BODY WHERE YOU ARE EXPERIENCING PAIN



Additional Notes About Condition:

On the pain scale, please indicate the CURRENT severity of your pain

PAIN SCORE 0–10 NUMERICAL RATING



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WHAT **AGGRAVATES** THIS COMPLAINT?

☐	Sitting	☐	Sleeping
☐	Standing	☐	Bending forward
☐	Standing for long periods	☐	Bending backward
☐	Walking	☐	Nursing
☐	Going sitting to standing	☐	Carrying child
☐	Going up stairs	☐	Twisting
☐	Going down stairs	☐	Reaching
☐	Lifting	☐	Exercising
☐	Desk Work	☐	Inactivity
☐	Sneezing	☐	Coughing
☐	Running	☐	Twisting
☐	Weight Lifting	☐	Rolling over in bed
☐		☐	
☐		☐	
☐		☐	

WHAT **IMPROVES** THIS COMPLAINT?

☐	Sitting	☐	Standing
☐	Laying down	☐	Rest
☐	Movement	☐	Stretching
☐	Massage	☐	Chiropractic Care
☐	Physical Therapy	☐	Medication
☐	Heat	☐	Ice
☐	Walking	☐	Exercise
☐	Nothing	☐	Unknown
☐		☐	
☐		☐	
☐		☐	

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HOW OFTEN ARE YOU EXPERIENCING SYMPTOMS?

Occasional 0-25% of Day	Intermittent 26-50%	Frequent 51-75%	Constant 76-100%
☐	☐	☐	☐

WHAT IS THIS INTERFERING WITH?

Sleep/ Work/ Exercise/ Walking/ Lifting/ Sitting/ Standing/ Getting up from chair/ Getting out of bed/ Social Activities/ Running/ Recreation/ House chores/ Yard work/ Personal Care/ Caring for children

OTHER PRACTITIONERS YOU'VE SEEN REGARDING THIS COMPLAINT

Primary Care Physician
Orthopedic Surgeon
Physical Therapist
Acupuncturist
Massage Therapist
Fasical Stretch Therapist

Other:

TYPES OF EXERCISE YOU PARTICIPATE IN

Walking
Running
Cycling
Weight Lifting
CrossFit
Martial Arts
Yoga
Pilates
Stretching
Dancing
Golf
Orange Theory/Boot Camp

Other:

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HEALTH HISTORY

Please check ALL Health Conditions that apply to you currently or have in the past			
☐	Osteoarthritis	☐	Whiplash
☐	Asthma	☐	Date of Injury:
☐	Type 2 Diabetes	☐	Headaches
☐	Type 1 Diabetes	☐	Migraines
☐	High Blood Pressure	☐	Joint Pain
☐	High Cholesterol		Type: Hip, Shoulder, Knee,
☐	Anema		Elbow, Ankle, Wrist
☐	Cancer		Other:
	Type:	☐	Osteoporosis/Osteopenia
☐	Depression	☐	Fibromyalgia
☐	Anxiety	☐	Epilepsy/Seizure
☐	Heart Disease	☐	IBS
☐	Stroke	☐	Ulcerative Colitis
☐	Hypothyroidism	☐	Cronh's Disease
☐	Hyperthyroidism	☐	Ehlers Danlos
☐	Rheumatoid Arthritis	☐	TMJ/Jaw Pain
☐	Trouble Sleeping	☐	Other:

FAMILY HISTORY: Please indicate conditions that apply to your immediate family (Father, Mother, Brothers, Sisters)		
☐	Cancer	Family Member:
	Type:	
☐	Diabetes	
☐	High Blood Pressure	
☐	Heart Disease	
☐	Stroke	
☐	Rheumatoid Arthritis	
☐	Genetic Disorders	

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SOCIAL HISTORY

Height:

Weight:

Do you smoke/use tobacco? YES NO

Do you drink alcohol? YES NO

Do you drink caffeine? YES NO

Coffee/ Tea/ Energy Drinks/ Other

Do you use over-the-counter pain medication? YES NO

Ibuprofen (Motrin)/ Acetaminophen (Tylenol) / Naproxen (Aleve)/ Aspirin

What does your work-day mainly entail?

Sitting/ Standing/ Manual Labor/ Driving/

What is your current overall stress-level?

Low/ Moderate/ High/ Overwhelming

How do you rate your current overall health?

Excellent/ Very Good/ Okay/ Fair/ Poor

Have you seen a chiropractor in the past? YES NO

Are you open to at-home exercises to help your condition? YES NO

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PAST INJURIES (LIST & DATE)

SURGERIES & HOSPITALIZATIONS (LIST & DATE)

CURRENT PRESCRIPTION MEDICATIONS (LIST & DOSAGE)

KNOWN ALLERGIES & REACTIONS

CURRENT VITAMINS & SUPPLEMENTS

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ELEMENT CHIROPRACTIC & WELLNESS
NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice please sign the bottom of this page and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - an open treating area means open discussion... If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor
5. For personal injury cases and workers compensation purposes - to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For public health and safety - in order to prevent or to lessen a serious or eminent threat to the health or safety of a person or general public
8. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
9. For military, national security, prisoner and government benefits purposes
10. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
11. Telephone calls, emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events
12. Change of ownership - in the event this practice is sold the new owners would have access to your PHI

Note: At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.

YOUR RIGHTS:

1. To receive an accounting statement of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Samantha Rybar at (248) 505-9170. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:
DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I understand that this office reserves the right to amend this notice of privacy practice at a time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of Element Chiropractic & Wellness' Patient Privacy Notice and I understand my rights as well as the practices to protect my health information. With my signature, I am conveying my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient or Legal Guardian Name: _____

Patient or Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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ELEMENT CHIROPRACTIC & WELLNESS
OFFICE POLICY & INFORMED CONSENT

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor, staff and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up to date. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Element Chiropractic does not participate in-network with any insurance plans. All patients are expected to make payments at time of service. For your convenience we accept HSA/FSA, cash, personal checks, Venmo and most major credit cards. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required. I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

Informed Consent

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, diagnostic x-ray, or tests Dr. Samantha Rybar or her staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the doctor and/or with office personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Name (Printed)

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ELEMENT CHIROPRACTIC & WELLNESS
CANCELLATION & NO-SHOW POLICY

Enforcing a cancellation/no-show policy is one of the more difficult things for Element Chiropractic & Wellness to do. However, it is necessary to ensure the high level of care we strive to provide for all patients. We reserve your appointment time specifically for you. If you do not show up for your appointment or cancel at the last minute, it becomes both a lost opportunity for another patient to receive care and a financial loss for the practice. We understand that unanticipated events can happen in life, but we aim to be fair to all patients and maintain a reputable practice.

CANCELLATION & NO-SHOW POLICY

Reminders will be sent via 'Square Appointments' 3 days prior and 24 hours prior to your appointment. Upon receiving the reminder, please click the link to confirm your appointment or text 248-505-9170 to reschedule. Appointments cancelled with less than 24 hours notice will incur a $35 cancellation fee.

LATE ARRIVALS

If you are running late for an appointment, please call the office to let the doctor know. Depending on how late you arrive, your appointment may be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours.

We thank you for your support of Element Chiropractic & Wellness and appreciate your cooperation.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Name (Printed)

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Dry Needling Consent Form

Dry Needling (DN) involves inserting a thin/flexible monofilament needle into symptomatic tissue to reduce pain and improve function. Benefits from DN can be experienced immediately or over a few days to weeks. DN is not Traditional Chinese Acupuncture. DN is based on anatomy, neurology, and physiology. DN has some risks that can occur with the treatment. In the hands of a skilled professional, these risks are small, but you should still be aware of the potential adverse events. The most likely adverse events are listed below by their level of severity ("Serious", "Significant", and "Mild") and how often it may occur ("Common" <10%, "Uncommon" <1%, and "Rare" < 0.1%).

Adverse Event	Likelihood	Additional Information
Serious Risks (may require hospitalization)		
Collapsed Lung (Pneumothorax)	Rare	Symptoms may include shortness of breath or chest pain that can last for many days to weeks. A more severe lung puncture can require a visit to the hospital.
Fainting (Syncope)	Rare	Symptoms leading to fainting may include: sweating; lightheadedness; dizziness. Let your healthcare provider know if you have any of these symptoms while being treated. People usually recover quickly but a medical exam may be needed if problems occur.
Significant Risks (May continue for days/weeks and can require medical care)		
Bleeding under skin resulting in a bump (Hematoma)	Uncommon	May result in a bruise.
Nerve Injury	Uncommon	May cause temporary numbness, tingling, weakness, or sensation changes. Needles are small, flexible, and do not have a cutting edge. Significant tissue trauma is unlikely.
Skin Irritation	Rare	Local redness, small bumps, and itching that may last a few hours.
Mild Risks (May cause temporary symptoms and little inconvenience)		
Bleeding (Droplet)	Common	Droplet is cleaned by healthcare provider but it may result in a bruise.
Bruising	Common	May last a few days.
Sweating (Diaphoresis)	Common	Usually occurs during or after treatment and may last minutes to a few hours.
Dizziness	Common	
Fatigue	Common	
Drowsiness	Uncommon	
Temporary Symptom Increase	Common	
Pain During/After	Common	Usually occurs during or after treatment and may last a few hours up to a few days.
Soreness	Uncommon	

There are other conditions that require consideration so please answer the following questions:

- Are you taking blood thinners? Yes / No
- Are you pregnant? Yes / No
- Are you receiving any treatments or have a medical condition effecting your immune system? Yes / No
- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes / No
- Have you experienced an allergic skin reaction to metals like chromium or nickel? Yes / No
- Do you have any medical devices or implants anywhere in your body? Yes / No
- Have you had any surgical procedures? Yes / No

Patient's Consent:
I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction. My signature below represents my consent to receive dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I,_____, read and understand the risks, all of my questions have been answered, and I am willing to be treated with dry needling.

_____
Patient or Authorized Representative Signature

_____
Date

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WOMEN'S HEALTH QUESTIONAIRE

Currently Pregnant ☐ YES ☐ NO ☐ UNSURE

Currently Breastfeeding ☐ YES ☐ NO

How Many Children Do You Have? ☐

Experienced a Miscarriage? ☐ YES ☐ NO

How Many Pregnancies Have You Had? ☐

Currently taking birth control? ☐ YES ☐ NO

Type? ☐

Through Menopause? ☐ YES ☐ NO

At What Age? ☐

Experiencing Peri/Menopause Symptoms? ☐ YES ☐ NO ☐ UNSURE

Please List Symptoms: ☐

Have you discussed your women's health concerns with your Primary Care Physician and/or OBGYN? ☐ YES ☐ NO

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WOMEN'S HEALTH QUESTIONAIRE

Please indicate any of the following symptoms you have experienced/are currently experiencing:

☐	Hot Flashes	☐	Migraines
☐	Night Sweats	☐	Dizziness
☐	Brain Fog	☐	Joint Pain
☐	Trouble Falling Asleep	☐	Muscle Aches
☐	Trouble Staying Asleep	☐	Osteopenia/Osteoporosis
☐	Mood Swings	☐	Heart Palpitation
☐	Weight Gain	☐	Shortness of Breath
☐	Difficulty Losing Weight	☐	Dry/Itchy Skin
☐	Irregular Periods	☐	Brittle Nails
☐	Fatigue	☐	Dry/Itchy Eyes
☐	Vaginal Dryness	☐	Hair Loss
☐	Decreased Libido	☐	Burning in the mouth
☐	Breast Tenderness	☐	Loss of bladder function
☐	Bloating	☐	Increased Allergies
☐	Digestive Issues	☐	Body Odor

Currently using Hormone Replacement Therapy (HRT)? ☐ YES ☐ NO

Type?