Enhanced Medical Centers

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. **PLEASE PRINT.**

Name_____ Today's Date_____
Last First Middle
Home Phone_____ Cell Phone_____ Email:_____
Address_____ APT/Unit #_____ City_____ State _____ Zip_____
Age_____ Birth date_____ Marital Status: S M W D Number of Children _____
Referred to our office by: _____
Is your condition due to an accident? Yes_____ No_____ Date of accident? _____
Type of accident? Auto_____ Work/On Job_____ At Home_____ Other_____
Have you ever been in an Auto Accident? Past Year____ Past 5 Years____ Over 5 Years____ Never_____

RESPONSIBLE PARTY INFORMATION

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____
Address _____Home Phone _____
E-Mail _____Cell Phone _____
Driver's License # _____ Date of Birth: _____
Is the person currently a patient at our office? □ Yes □ No
Do you have any Medical Insurance? □ Yes □ No If yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____
Address of Employer_____ State _____ Zip_____
Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____ City _____ State _____ Zip_____
Person to contact in case of an emergency_____ Phone_____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AN AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Enhanced Medic Centers as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Providers; consistir of, Dr. Erik Schutt, D.C., Dr. Martin Gruenberg D.O., and/or Adam Yngelmo, PA-C "), the balance due on my account for any professional services render and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefi directly to Healthcare Providers for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will b* rendered or provided; as well as designating and appointing Healthcare Providers as my beneficiary under all health insurance or medical plans which may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your recor that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to ar unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Providers a rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governe plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicab health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Providers can act on my/our behalf, as my/our Person Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information fro the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or prote benefits and/or payments that are due (or have been previously paid) to either Healthcare Providers, myself, and/or my family members as a result services rendered by Healthcare Providers, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against th health plan, the insurer, or any administrator. I hereby also declare that Healthcare Providers is my/our beneficiary regarding my/our health plan contemplated by both ERISA and PPACA, and that Healthcare Providers can pursue any and all rights that I/we may have under state and/or federal la regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that th effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided t Healthcare Providers.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient or Guardian Signature_____ Date_____

List your Pain/Complaints from Most Severe (Pain #1) to Least (Pain #4)

Patient Name: **Date:**

Today, you have the following physical complaints:	**Location of Pain #1**	**Location of Pain #2**	**Location of Pain #3**	**Location of Pain #4**
	_____	_____	_____	_____
	_____	_____	_____	_____
Is this Complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Shooting ☐ Other_____	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Shooting ☐ Other_____	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Shooting ☐ Other_____	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Shooting ☐ Other_____
How often do you feel this complaint? Constant, Daily, Off and On, Weekly?	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly
How long as this been going on?	_____	_____	_____	_____
	_____	_____	_____	_____
Since it began, is it getting:	☐ Worse ☐ No change ☐ Better	☐ Worse ☐ No change ☐ Better	☐ Worse ☐ No change ☐ Better	☐ Worse ☐ No change ☐ Better
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
Rate discomfort on scale (1-10)	10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No discomfort	10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No discomfort	10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No discomfort	10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No discomfort
This issue is affecting my:	☐ Job ☐ Childcare ☐ Marriage/Sex ☐ Finances ☐ Golf/Hobbies	☐ Job ☐ Childcare ☐ Marriage/Sex ☐ Finances ☐ Golf/Hobbies	☐ Job ☐ Childcare ☐ Marriage/Sex ☐ Finances ☐ Golf/Hobbies	☐ Job ☐ Childcare ☐ Marriage/Sex ☐ Finances ☐ Golf/Hobbies
Helping this issue would increase the quality of my life by:	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%	☐ 10-30% ☐ 40-75% ☐ 80-100%

**People see Chiropractors for a variety of reasons. Your needs will be based upon the evaluation performed.
Please check what type of care is most appealing to you. (CHECK ALL THAT APPLY)

{ } TEMPORARY RELIEF { } CORRECTION OF CAUSE { } PREVENTION { } LET DOCTOR CHOOSE FOR ME

Health History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES	Hepatitis.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES	Ulcer.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES	Kidney Disease.....	NO	YES
Whooping Cough...	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES	Thyroid Disease.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray_____			Bleeding Tendency.....	NO	YES
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES	Any Other Disease.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES	(Please List):		
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES			
Rheumatic Fever...	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES	_____		
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES			
Venereal Disease...	NO	YES	Blood or Plasma Transfusion.....	NO	YES	Mitral Valve Prolepses....	NO	YES	_____		
						Stroke.....	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription) **IF MORE ROOM IS NEEDED PLEASE ADD TO THE BACKSIDE OF THIS FORM OR PROVIDE US WITH A LIST**

_____

_____

Drug Allergy: NO YES if yes, drug 1 : _____ drug 2:_____ type of reaction:_____

If more space is needed please add to back of form_____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months / **1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly**

Eyes/Ears/Nose/Throat/Respiratory		Muscular/Skeletal		Neurological		General	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5	Pins/needles	1 2 3 4 5	Constipation	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	in hands or feet		Diarrhea	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5			Feeling foggy	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5			Forgetfulness	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5				
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5				
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5				
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5				
Wheezing	1 2 3 4 5						

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

ALLERGY HISTORY

Patient Name _____ Date. _____

Patient Number _____ Age _____ M/F

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTS:
Please circle the appropriate number 0 to 3 according to severity:
0 = absent (no symptoms evident) **2 = moderate** (tolerable)
1 = mild (symptoms present, but minimal awareness), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itching ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus pain	0	1	2	3

Other symptoms causing you problems?
_____

MEDICATIONS:
How often do you take medications for your allergy symptoms?
0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week)
3 = daily

Antihistamines	0	1	2	3	Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids	0	1	2	3	Asthma medication (Inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medications _____				

Does any medication give you complete relief of symptoms? _____

GENERAL ALLERGY HISTORY:
How many months of the year do you have allergies? _____ How many years? _____
In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O Blood draw
Have you previously received allergy shots? _____ Allergy drops? _____ If yes, when? _____
Do you smoke or use tobacco products? _____
List any animals you have in or around the home _____
Who else in your family has allergies? _____

PROVIDER ONLY
RAW SCORE: _____ /25 0-25 = MILD 26-50=SIGNIFICANT
SCORE: _____ (Multiply raw score by 4) 51-100 = SEVERE 100+= VERY SEVERE

Please Review Our Appointment Policy

We are growing! ... and, so excited to be treating more and more members of our community in their pursuit of better health and wellness.

As a result, we find it necessary to implement a new appointment policy. We value your time very much, and hope that you value ours as well.

When we schedule an appointment together, we have reserved that date and time for YOU! Appointments cancelled less than 24 hours in advance or missed appointments, affect other patients who could've benefited from a treatment that day.

Beginning immediately, $45 will be charged to your account for a missed injection, rehab, acupuncture, and / or massage appointment. This fee will also apply to cancellations without 24 hours notice. If you enjoy our auto debit or prepay discounts, unfortunately, you will lose the prepaid visit that was missed, or not cancelled 24 hours prior to the scheduled appointment time.

In addition, late arrivals may not be able to be accommodated, also resulting in a fee assessed to your account, or forfeiture of that scheduled prepaid treatment. If you think that you will be late for your appointment, please call us as soon as possible, so we can determine if your late arrival can be accommodated.

And lastly, while there will be no fee assessed for missed chiropractic adjustment only visits at this time, we request that our chiropractic only patients also exercise consideration for missed and late arrival appointments, as this will dramatically increase our ability to continue to assist you in achieving your health goals with the minimal amount of time taken out of your daily schedule.

By signing below, I acknowledge that I have read and agree to the above.

_____

Print Name

_____ _____

Signature of Patient Date