Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
SS#: - -	DOB:	Sex: M F
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft. in.
City:	State: Zip:	Weight: lbs.
Email:	Cell Phone: - -	Other Phone: - -
Emergency Contact:	Emergency Relation:	Emergency Phone: - -

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? Yes No

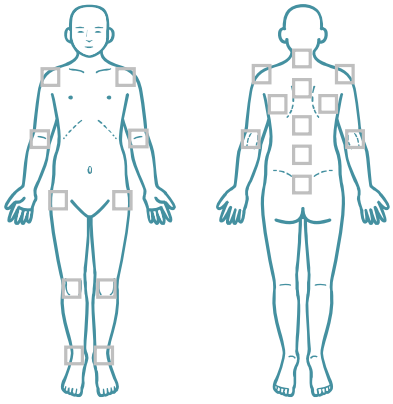
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.



Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

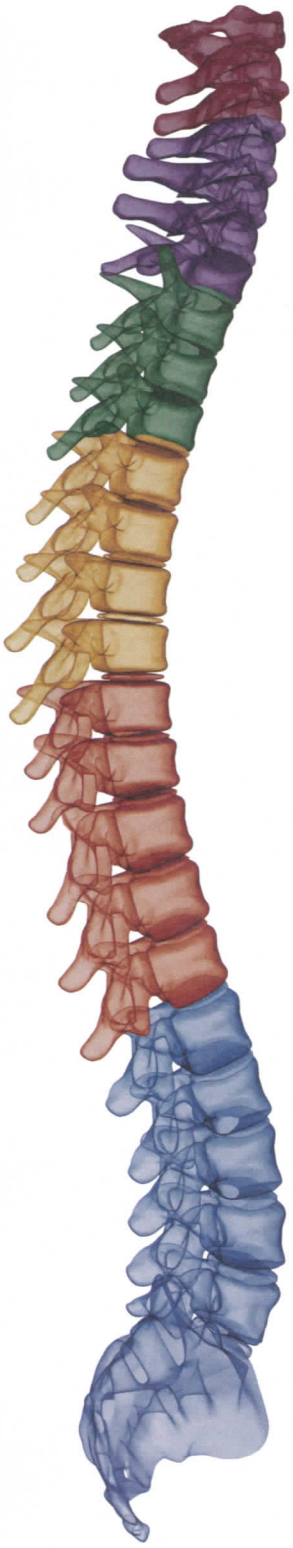
Patient Name: _____ _____

Vibrant Wellness | Shaun Olsen DC | (678) 506-1665
12655 Birmingham Hwy Suite 302 Milton GA 30004
vibrantwellnesschiro@gmail.com | vibrantwellnesschiro.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Crohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___

Vibrant Wellness

Fee Schedule and Guidelines

New Patient Consultation: Free

Initial Visit: $200

The Initial Exam includes Neuro-Structural Evaluation, Spinal Diagnostic Scans, Digital Postural Assessment, Orthopedic and Neurological testing, Muscle testing and other procedures as needed. Report of Findings and Recommendations is included at subsequent visit.

Note: If on First Visit it is determined you are candidate for care and established as patient, initial Procedures and Entrainment/Adjustment will begin on this visit.

Established Patient:

Spinal Entrainment or Gentle Force/Tonal Chiropractic Adjustment	$50
Standard Visit: Applied Kinesiology Reflex Analysis with Chiropractic	$100
Adjustment or Modality – approximately 30 minutes	
Extended Visit: Applied Kinesiology Reflex Analysis with Chiropractic	$150
Adjustment or Modality – approximately 60 minutes	
Auriculotherapy/Cranial Nerve Augmentation	$50

Nutritional Supplements are extra, based on your individual program

Our patients pay for care "out of pocket" because we do not file insurance or accept Medicare or Medicaid Patients. We utilize uniquely designed cash plans to allow you to receive all the care necessary as determined by your chiropractic evaluation.

Signature: _____ I have read and understand the fee schedule for the services available at this office. Date: _____

12655 Birmingham Hwy STE 302 Milton GA 30004 – (678) 506-1665 – vibrantwellnesschiro@gmail.com

Vibrant Wellness
Shaun Olsen DC
NPI: 1952915357, TIN: 85-1879412
12655 Birmingham Hwy Suite 302 Milton GA 30004
678-506-1665

Good Faith Estimate

Patient Name:	Date of Birth:

Estimated Services and Items

Date of Appointment	

Description **Initial Visit**	**Diagnosis Code (ICD-10 Code)**	**Service Code (CPT, HCPCS, DRG)**	**Quantity**	**Expected Cost**
Primary Service				
Exam		99203	1	100.00
Applied Kinesiolgy Reflex Procedure		97139A	1	50.00
Spinal Entrainment/ Adjustment		97139N or 97139T	1	50.00

P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)	**Total Expected Charges $**	200.00
	Date of Good Faith Estimate:	

Disclaimers: There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate.

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.

This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate. Patient Signature: _____ Date: _____