Anodyne of Newark

New Patient Information

Name:_____ Date:_____
Date of Birth:_____ Age:_____ Gender:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____
Email:_____ SSN:_____
Marital Status: Single / Partnered / Engaged / Married / Divorced / Widowed / Other:_____
Spouse/Partner's Name: _____
If you are a minor, please list your parents/guardians:_____

Name of Emergency Contact:	Relationship:	Phone Number:

Primary Care Physician:_____ Clinic Name:_____
Phone Number:_____ Date of Last Visit:_____
How did you hear about Anodyne Pain & Wellness?_____
Have you ever received chiropractic care?_____

Name of Chiropractor:	Date of Last Visit:	Reason for Previous Care:

Social History

Tobacco:	YES / NO / Quit Date:_____	Type:_____	Amount:_____
Alcohol:	YES / NO / Quit Date:_____	Type:_____	Amount:_____
Drugs:	YES / NO / Quit Date:_____	Type:_____	Amount:_____
Exercise:	YES / NO	Type:_____	Amount:_____
Caffeine:	YES / NO	Type:_____	Amount:_____
Special Diet:	YES / NO	Type:_____	Amount:_____
Occupation:	Working / Retired / Unemployed / Student		
	Employer/School: _____		
	Occupation: _____		
Stress Level:	Low / Moderate / High		
Recreation:			
Living Situation:	Alone / Roommate / Family / Other:		
Concerns about sexual health or abuse: YES / NO			

Family History

Diagnosis	Family Member

Allergies/Adverse Reactions to Medications

Medication	Reaction

☐ No Known Allergies

Patient Initials:_____

Reason for becoming a patient?	
Have you been treated for this before?	YES / NO Provider who treated you:
Is this condition due to an accident?	YES / NO Date: Type: Auto / Work / Home / Other:
To whom have your reported the accident?	Auto Insurance / Employer / Workers Comp Police / Other:
Attorney name if applicable:	

Please answer the following questions about your symptoms to the best of your ability.

Problem/Concern #1:	
When did this originally begin?	
If this is a chronic problem with a flare up, when did this current episode begin?	
Is it getting better, worse, or staying the same?	
When is it the worst?	Morning / Night / Always / When Active / Other:
Pain scale from 0-10	
How often do you experience it?	Occasional / Comes & Goes / Frequent / Constant
What does the pain feel like?	Sharp / Achy / Dull / Electric / Shooting / Tight / Burning Numbness / Tingling / Throbbing / Pinching / Soreness
Does the pain radiate or travel anywhere?	YES / NO Where: How Often?
Do you have any other associated symptoms?	
What makes it worse?	Sitting / Standing / Bending / Walking / Stairs / Driving Sleeping / Working / Being Active / Other:
Does it interfere with:	Work / Sleep / Self Care / Daily Routine / Recreation
What makes it better?	
What have you tried to help it?	Ice / Heat / Reduced Activity / Stretching / Chiropractic PT / Braces / Injections / Medications / Surgery / Other

Please answer the following questions about your symptoms to the best of your ability.

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As healthcare providers we are concerned about your overall wellness. On future visits we will discuss issues with you that may impact your overall health. All of the answers I have given are correct to the best of my knowledge and I agree to have an examination performed at Anodyne Pain & Wellness at this time.

Signature:_____ Date:_____

Signature of Legal Representative:_____ Relationship:_____ Date:_____

Past and Current Medical Problems

Please include the year of diagnosis and any additional information.

Condition	**NO**	**CURRENT**	**IN THE PAST**	**Year Diagnosed and Additional Information**
AIDS/HIV				
Allergies				
Arthritis				
Asthma				
Autoimmune Disease				
Bleeding Disorder				
Cancer				
COPD				
Diabetes				
Digestive/Intestinal Problems				
Ear Problems				
Eye Problems				
Genital/Urinary Problems				
Headaches				
Heart Attack				
Heart Failure				
Other Heart Problems				
High Blood Pressure				
High Cholesterol				
Infectious Diseases				
Joint/Muscle Problems				
Joint Replacement				
Kidney Problems				
Liver Problems				
Lung Problems				
Mental Illness				
Migraines				
Neurological Problems				
Osteoporosis				
Pacemaker/Defibrillator				
Seizures				
Stroke/TIA				
Substance Abuse				
Throat Problems				
Thyroid Disease				
Other				

Patient Initials:_____

Do you use any of the following: wheelchair / walker / cane / braces / shoe inserts

Please give additional information about medical problems and medical equipment here:

_____

_____

_____

Current Prescription Medications, Over The Counter Medications, Topical, and Supplements

Medication/Supplement	Dose & Frequency	For how Long?	For what condition?

☐ Denies any use of medications or supplements

Preferred Pharmacy & Address:_____

Pharmacy Phone Number:_____

Past Injuries

Falls:	Year:
Fractures/Dislocations:	Year:
Head Injuries:	Year:
Other:	Year:

Past Surgical History/Hospitalizations

Surgery/Reason for Hospitalization:	Year:	Complications:

☐ Denies any past surgeries and/or hospitalizations

Patient Initials:_____

X-Ray Questionnaire

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant or aware of any other conditions at this time which might conflict with taking x-rays. By signing, you understand that there are risks associated with x-rays and that you give consent to receive x-rays if the provider deems them necessary.

Name: _____

_____ Yes _____ No I am pregnant at this time.

_____ Yes _____ No I am aware of any medical condition that may prohibit me from being x-rayed.

I request that x-rays not be taken at this time because:

_____

_____

_____ _____

Patient/Guardian Signature Date

Anodyne of Newark
2600 Glasgow Avenue, Suite 200, Newark, Delaware 19702
Phone: (302) 289-5425

Patient Financial Responsibility
I understand and agree that if I have health an/or accident insurance policies, that these policies are an arrangement between my insurance company and myself. Any amount paid to this office will be credited to my account upon receipt. I understand that my insurance policies may cover part, or none of the services rendered. I clearly understand that all services rendered to me are my personal responsibility.

Cancellation Policy
Late cancellations of less than 2 hours, and patients who do not show for a scheduled appointment will be charged $25.00. We do not accept walk-in appointments.

We send appointment reminders via text message and email. Please provide the following:

Cell Phone Number:_____ Carrier:_____

Email Address:_____

Authorization to Pay Doctor Directly
I authorize the direct payment to my doctor from my insurance company that is contractually obligated to pay my doctor directly out of any proceeds of any settlement I may receive. A photocopy of this form is acceptable for this authorization.

Authorization to Release Patient Information
I authorize this office to release any information requested by a third party that presents a signed release bearing my signature.

Notice of Your Privacy Rights
I acknowledge that Anodyne of Newark provides the opportunity to review the Notice of Privacy Practices. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operation at Anodyne of Newark. The Notice of Privacy Practices for Anodyne of Newark is also provided upon request at the main administration desk. The Notice of Privacy practices also describes my rights and Anodyne of Newark's duties with respect to my protected health information. Anodyne of Newark reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy or by asking for one at the time of my next appointment.

I have read, fully understand, and agree to abide by the above policies.

Printed Name:_____

Signature: _____ Date:_____

Signature of Parent or Legal Guardian:_____ Relationship:_____

Informed Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, or course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it know or to learn through healthcare procedures from whatever he/she is suffering from. latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. these examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill any controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be prescribed by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here:_____ I have read and understand the above consent form.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices of_____.
(please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in this office. If I should have a problem or question in regards to my rights, I may speak with a Privacy Practice officer about my concerns.

This serves as notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (withing reason) in writing.

Signature of Patient/Guardian:_____ Date:_____

Witness (Office Staff):_____ Date:_____

Anodyne of Newark
2600 Glasgow Avenue, Suite 200, Newark, Delaware 19702
Phone: (302) 289-5425

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records to the physician/entity listed below.

Patient Name:_____ Date of Birth:_____

You may release my complete medical records subject to this signed release form.

Release my protected health information to the following phsyician/person/facility/entity and/or those directly associated in my medical care.

Anodyne of Newark
2600 Glasgow Avenue, Suite 200, Newark, Delaware 19702

Patient Name	Signature of Patient or Patient Representative
Patient DOB or Social Security Number	Printed Name of Patient or Representative

Date