Dr. Ron T. Dümmar DC, MAOM
*Natural Health Physician*
*Acupuncture - Chiropractic - Herbal Medicine*

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## ABOUT YOU

Full Name: ______________________
What do you prefer to be called? ______________________
Date of Birth: ______________________ Age ______
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Sex: M F # of Children: __________
Race: (circle) Caucasian/Hispanic/Asian/Black/Hawiian/Indian
Primary Language: ______________________
Social Security #: ______________________
Mailing Address: ______________________
City: ______________ State: ______ Zip: ________
Phone: (______) ____________ Cell: (______) ____________
Email: ______________________
Employer's Name: ______________________
Primary Care Physician: ______________________
Who may we thank for this referral? ______________________

**In the event of an emergency:**

Contact: ______________________
Phone: (______) ____________ Relationship: ____________

## CONSENT TO TREAT A MINOR

I hereby authorize the physicians at Community Health and Wellness and whomever they may designate as their assistants, to administer treatment and X-Rays as they deem necessary to my son/daughter.

Signature: ______________________ Date: __________
Relationship to Minor: ______________________

## MEDICAL HISTORY

Are you here for injury from an auto accident? Y N
Are you here for an injury from a work accident? Y N
Have you been diagnosed with anything? ______________________
______________________________________________
Allergies: ______________________
Medications: ______________________
Allergies to Medications: ______________________
Do you (smoke) or (chew) tobacco? Past Present Never
Do you have any blood disorders? ______________________
What imaging studies have you had in the past 12 months?
☐ X-Rays ☐ CT ☐ Bone Density ☐ EKG ☐ MRI
Recent weight loss? If so, how much? ______________________

**Please indicate if any of the following pertain to you:**

☐ Hepatitis ☐ HIV ☐ High Blood Pressure
☐ Seizures ☐ Pacemaker ☐ Blood Thinning Meds
☐ Pregnant? How far along? ______________________

**Check all that apply to your Personal Health Concerns:**

☐ Ear, Eyes, Nose & Throat ☐ Cardiovascular
☐ Urinary Issues ☐ Gastrointestinal
☐ Skin Problems ☐ Musculoskeletal
☐ Respiratory Complaints ☐ Neurological
☐ Reproductive Health ☐ Mental Health

**Questions about your General Health:**

Sleep well? Y N Experience Fatigue? Y N
Night sweats? Y N Spontaneous sweating? Y N
Rate your energy level from 1(low) to 10 (high): ________
Rate your stress level from 1(low) to 10 (high): ________
I often feel: Warm Cold I prefer to drink: Warm Cold

## ASSIGNMENT OF BENEFITS • RELEASE • RESPONSIBILITIES

*We invite you to discuss any questions you may have regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.*

I hereby authorize payment of benefits directly to the provider of benefits due me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed by indebtedness to the assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I further authorize physician and/or supplier to release information required to process insurance claims. Should my contract prevent payment, I request that any draft issued me, be made jointly payable to Community Health and Wellness, PLLC.

- I understand it is my responsibility to inform this office of any changes in my medical status.
- If I need to cancel an appointment, I will call **24 hours in advance** so another patient can be booked in my time slot. A "no show" without cancellation notice may result in a **$25.00 fee**. I will also be **on time** for all appointments.
- I understand that CHW will provide me with copies of my personal health records upon request.

Signature of Responsible Person: ______________________ Date: __________

# PATIENT HEALTH HISTORY

**Supplements/Reason for taking**

| | |
|---|---|
| | |
| | |
| | |
| | |

**Medications/Reason for taking**

| | |
|---|---|
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**Surgeries (Date, Area, Reason)**

| | |
|---|---|
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| | |

**RESPIRATORY**
- ☐ Cough more than 3 mo.?
- ☐ Bronchitis/Pneumonia
- ☐ COPD or Emphysema
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum, color?
- ☐ Spitting up blood

**EAR, EYES, NOSE, THROAT**
- ☐ Head Injury
- ☐ TMJ (Jaw Pain)
- ☐ Glasses/Contacts
- ☐ Tearing or Dryness
- ☐ Glaucoma or cataracts
- ☐ Ringing in Ears (Tinnitus)
- ☐ Hay Fever
- ☐ Sinus problems
- ☐ Frequent Sore Throat
- ☐ Bleeding Gums
- ☐ Swollen Lymph nodes
- ☐ Hypo/hyper thyroid
- ☐ Hearing Loss
- ☐ Other:

**URINARY**
- ☐ Pain on urination
- ☐ Increased Frequency of Urination
- ☐ Inability to hold/dribble?
- ☐ Frequent infections or kidney stones

**CARDIOVASCULAR**
- ☐ Heart Disease
- ☐ Angina or Pain in Chest
- ☐ High Blood Pressure
- ☐ COPD or Emphysema
- ☐ Rheumatic Fever
- ☐ Swelling in ankles
- ☐ Palpitations or fluttering
- ☐ Murmur or Mitral valve prolapse
- ☐ Poor Circulation
- ☐ Pacemaker

**MUSCULOSKELETAL & NEUROLOGICAL**
- ☐ Joint Pain or Stiffness
- ☐ Muscle spasms/cramps
- ☐ Muscle weakness
- ☐ Deep leg pain
- ☐ Varicose Veins
- ☐ Seizures
- ☐ Paralysis
- ☐ Numbness, tingling or shooting pain
- ☐ Memory loss
- ☐ Anxiety
- ☐ Headache or Migraine
- ☐ Dizziness/Vertigo
- ☐ Fainting
- ☐ Spinal Cord Injury
- ☐ Concussion

**GASTROINTESTINAL**
- ☐ Heartburn
- ☐ Belching or Passing Gas
- ☐ Nausea, how often?
- ☐ Vomiting, how often?
- ☐ Constipation or diarrhea
- ☐ Bloating
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Jaundice

| Family Health History | Self | GPA | GMA | DAD | MOM | SIB |
|---|---|---|---|---|---|---|
| Alcoholism | | | | | | |
| Arthritis | | | | | | |
| Asthma | | | | | | |
| Cancer | | | | | | |
| Chronic Fatigue | | | | | | |
| Depression | | | | | | |
| Diabetes | | | | | | |
| Epilepsy | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Problems | | | | | | |
| Multiple Sclerosis | | | | | | |
| Neurological Problems | | | | | | |
| Parkinson's Disease | | | | | | |
| Stroke | | | | | | |
| Thyroid Problems | | | | | | |
| Ulcer | | | | | | |
| | | | | | | |

**FEMALE REPRODUCTIVE**

Age of first period?
Date of last period?
Days between periods?
Number of Days of Flow?
Flow: Heavy/Moderate/Light
\# of live births? # of preg.?

- ☐ PMS: Swollen Breasts/ Mood Swings
- ☐ Anemia
- ☐ Headache
- ☐ Nausea
- ☐ Vaginal Discharge
- ☐ Insomnia
- ☐ Appetite Change
- ☐ Fibroids
- ☐ Fibrocystic Breasts
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Polycystic Ovarian Synd.
- ☐ STDs or HPV
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Amenorrhea
- ☐ Birth Control Pills
- ☐ Hormone Replacement
- ☐ Hot Flashes

**SWEAT QUESTIONS**
1. Experience Thirst? Dry Mouth? Dry Throat?
2. Weak or painful low back or knees?
3. Dizziness? Or Weakness?

**SKIN**
- ☐ Rashes
- ☐ Eczema or psoriasis
- ☐ Hives
- ☐ Acne
- ☐ Itching
- ☐ Color Change
- ☐ Lumps
- ☐ Boils

**MALE REPRODUCTIVE**
- ☐ Hernias
- ☐ Testicular Pain or Masses
- ☐ Prostate Disease
- ☐ Sexual Difficulties
- ☐ STDs or HPV
- ☐ Discharge or sores

**SLEEP QUESTIONS**
1. Difficulty falling asleep?
   -Racing Thoughts?
2. Waking up at night?
   -What time?

**FATIGUE QUESTIONS**
1. What time of day?
2. Bloating or GI Issue?
3. Difficulty losing weight?
4. Muscle aches or soreness?
5. Sensation of heaviness?

## HISTORY OF PRESENT INJURY

**List your current complaints** (from most to least severe) & **Rate your pain intensity** (scale of 1-10, with 10 being the worst)

#1. ______________________ Pain Rating

**How would you characterize your pain?**
- ☐ Sharp/Stabbing
- ☐ Dull/Achy
- ☐ Numb
- ☐ Burning
- ☐ Throbbing
- ☐ Tingling
- ☐ Shooting
- ☐ Weakness

**What is the frequency of your pain?**
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

#2. ______________________ Pain Rating

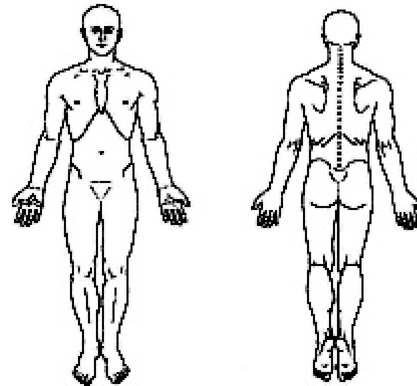
**How would you characterize your pain?**
- ☐ Sharp/Stabbing
- ☐ Dull/Achy
- ☐ Numb
- ☐ Burning
- ☐ Throbbing
- ☐ Tingling
- ☐ Shooting
- ☐ Weakness

**What is the frequency of your pain?**
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

#3. ______________________

**Please explain any other complaints below:**

Please indicate on the figures below the areas of the body where you experience pain:



Does the pain wake you up at night? Y N

Are your symptoms (circle one): Increasing Decreasing Not Changing

What time of day are your symptoms worse (circle one)? Morning Afternoon Night Same all day

When did your problem begin? (Specific Date) ____________

How did your problem begin? ______________________

What makes your problem BETTER? ______________________

What makes your problem WORSE? ______________________

Do you find it difficult when? Walking Standing Sitting Bending Lifting Riding Working

Have you taken any medications for this specific condition? Y N Have they helped? Y N

Have you been treated elsewhere for THIS EPISODE? Y N What was the diagnosis given? ____________

If treated, by whom? ☐ Chiropractor ☐ M.D. ☐ Osteopath ☐ Physical Therapist ☐ Massage Therapist ☐ Other

What treatment was performed? ______________________ Did it help? Y N

Name of the Practitioner who treated you: ______________________

## ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, ______________________ , have read a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

I understand that a full printout of the Privacy Practices of this office will be available to me at my request.

Printed Name: ________________ Signature: ________________ Date: ____________

## FINANCIAL POLICY

Our primary concern is your health. Below are the options available to address your financial needs. Please read the following and select the most appropriate option. Sign where indicated.

All charges for ***supplies***, ***supplements*** and ***herbal prescriptions*** must be paid for at the time they are received.

All fees charged at this office are comparable to those charged by other specialists with similar qualifications in this geographic area. Our office policy requires payment in full for all services rendered at the time of service at the time of each visit unless other arrangements have been made. A late fee of 15% will be charged for each 30 day period that the account is overdue.

- If the account is not paid within 90 days of the date of service, I will be responsible for any expenses incurred in collecting my account.
- If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection charge of 40%, which will be added to the outstanding balance of my account.
- I understand and agree to the above policy and will abide by the terms of the payment option I have initialed below:

__________ **Time of Service Patient:** Payments will be made in full on the date of service. I understand that I will receive non-billing discounted prices. (Current rate = 15%)

__________ **Medicare/Supplement:** Medicare covers a portion (80%) of **adjustments only**, after your deductible has been met. Medicare DOES NOT cover exams, X-Rays, Therapy or Supplies. **No maintenance care** will be covered, **care must be medically necessary to be a covered service.**

__________ **Private Health Insurance:** I am responsible for all co-payments, coinsurance and deductibles. We will submit your bill to your primary insurance and credit you for any balance we receive as a result of payment from your insurance carrier. I understand that the bill is my responsibility if the insurance carrier denies payment.

__________ **Personal Injury Cases:** If you have been in a collision, we will bill your auto insurance company. In Utah each patient is given $3,000 for treatment toward health care as a result of a collision. This applies whether the crash was your fault or not. You will have no deductible or co-payment.

Printed Name: ____________________ Signature: ____________________ Date: ____________

## INFORMED CONSENT TO TREATMENT AND CARE

I hereby request and consent to the performance of procedures which are within the scope of a Chiropractic and Naturopathic Physician including, but not limited to, chiropractic adjustments, various modes of physiotherapy, diagnostic x-rays, IV therapy and injection therapy. I also consent to the performance of procedures that are within the scope of the practice of Acupuncture and Oriental Medicine including, but not limited to, acupuncture, moxibustion, cupping, electro-acupuncture and herbal medicine by the doctors at Community Health and Wellness.

I understand and am informed that there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight bruising, bleeding, tingling near the needling sites that lasts for a few days, nausea, infection and blisters. There have been instances of fainting, infections and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the doctor.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, and based upon the facts known, is in my best interests.

I have read, or have had read to me, the above consent. I have had the opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of naturopathic and chiropractic medicine, adjustments and therapy, and the nature of acupuncture and herbal medicine treatments. By signing below, I agree to the above named procedures. I intend for this consent to cover my entire course of treatment for my present condition and any future condition(s) for which I may seek treatment.

Printed Name: ____________________ Signature: ____________________ Date: ____________

Witness Signature: ______________________________