LINCOLN WELLNESS CENTER

RELEASE THE HEALING WITHIN

Welcome to the beginning of optimal health!

Lincoln Wellness Center would like to thank you for choosing us to partner with you as you embark on your journey towards optimal health! We've developed this guide to help you prepare for your new patient appointment.

For us to begin designing your personalized treatment plan, we need to know a little more about you. There are several online forms that must be completed and submitted a **minimum of three (3) business days** prior to your new patient appointment.

- ❖ Go to drstanschulte.com/new-patient-paperwork/
- ❖ Follow the instructions to complete all the steps.

Please read the following frequently asked questions. Initial after each question.

What do I need to bring to my new patient appointment? _____ **(initial)**

- This form - completed and signed.

How long will my first appointment last? _____ **(initial)**

- Anywhere from 30 to 45 minutes depending on the patient.
  This allows for a thorough review of your history; a physical examination; and any lab testing deemed necessary. We also allow ample time for you to ask questions.

Are my office visits billable to insurance? _____ **(initial)**

- We are not an insurance-based office, therefore chiropractic exams, x-rays, scans, manipulations (aka adjustments), and nutrition services are not billable to insurance. However, you may utilize an HSA or Flex account.

Will there be a potential for lab work and if so, how are labs billed? _____ **(initial)**

- Lab work results are very important and will typically assist the doctor in determining the plan of care. If prior lab work has not been completed; our doctors may recommend lab testing at your first appointment. This typically involves blood work or test kits.
- If labs are necessary, additional testing and billing options will be discussed at the time the patient receives the lab.

LINCOLN WELLNESS CENTER
RELEASE THE HEALING WITHIN

Will I need supplements, and if so, how long will I have to be on these supplements? _____ **(initial)**

- Most patients with nutritional health concerns will have supplements recommended. Each supplement is chosen for the patient for a specific reason based upon the symptoms described to the doctor, as well as the results of any lab testing. The doctor will get into further details about the supplements ordered for you at your second appointment. The intent is always for the patient to eventually lessen the number and/or dosage of supplements, but the timeline for this is different for each patient and is based upon the improvement of the patient's condition over time. Often improvements are seen by 3-6 months and again at 9-12 months, however, results may take longer if patient fails to implement the dietary recommendations. Due to quality control, all supplements are non-refundable.

Non-Chiropractic Appointment Cancellation Policy Agreement _____ **(initial)**

- Lincoln Wellness Center is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.
- **Please call us (402) 420-0024 by 2:00 p.m. two days prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.** If prior notification is not given, you will be charged $100 for the missed appointment.

We look forward to seeing you at your new patient appointment soon, and we are excited to work with you to help you achieve optimal health. Please print your name, sign below, and bring this letter to your new patient appointment.

_____ _____

Printed Name Signature

Sincerely,
Dr. Schulte and Staff of Lincoln Wellness Center

PATIENT APPLICATION SURVEY

Name: _____ Preferred Name: _____

Birth Date: _____ / _____ / _____ (Age) _____

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Gender: M F Language: English or Other:_____ Race: White Hispanic African American or Other:_____

Height: ___Feet ___Inches Weight:_____ Blood Pressure: ____/____ Smoker: Yes Never Former Marital Status: S E M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____

Is this purpose related to an auto accident / work injury? □ Yes □ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe:_____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

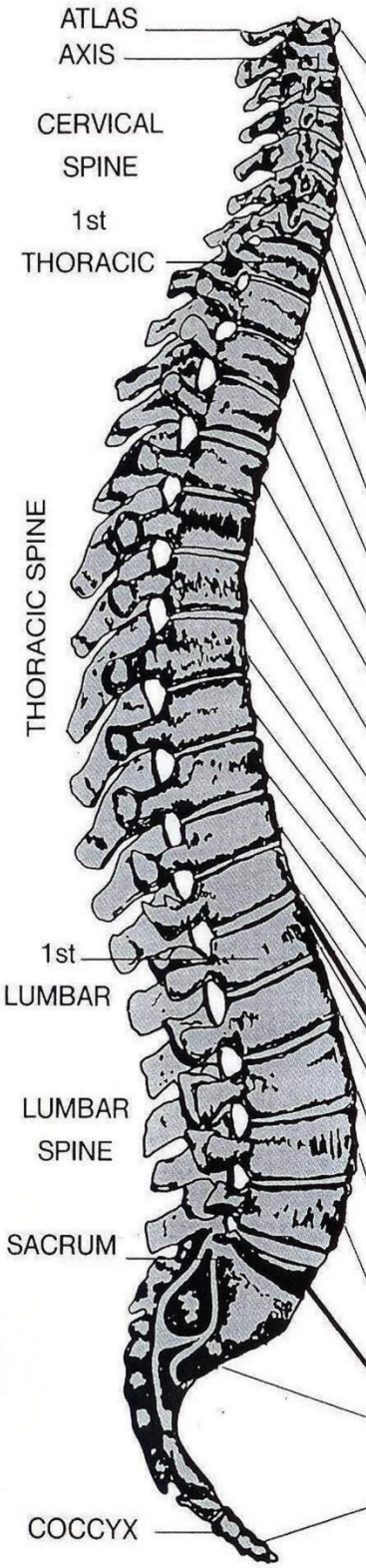
Explain: _____

Please check any health condition you may be experiencing, now or in the past

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

Past & Current Symptoms / Health Concerns

PLEASE CHECK ALL BOXES ⬇ THAT APPLY



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction	
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.	NECK REGION
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.	
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.	
4C	Nose, lips, mouth, eustachian tube.	☐hay fever,☐runny nose,☐hearing loss,☐adenoids.	
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.	
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.	
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.	
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.	MID-BACK
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.	
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.	
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.	
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.	
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.	
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.	
8T	Spleen.	☐ lowered resistance.	
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.	
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.	
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.	
12T	Small intestines, lymph circulation.	☐rheumatism,☐gas pains, ☐certain types of sterility.	
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.	LOW BACK
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.	
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.	
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.	
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.	PELVIS
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.	

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

LIFESTYLE & DIET

Do you exercise? ○Daily ○ Weekly ○Occasionally ○Never

What activities? ○Running ○Jogging ○Weight ○Training ○Cycling ○Yoga ○Pilates ○Swimming _____

Do you smoke? ○Daily ○Weekly ○Occasionally ○Never

If so, how much? _____

Do you drink alcohol? ○Daily ○Weekly ○Occasionally ○Never

If so, how much? _____

Do you drink caffeinated drinks & products (i.e. coffee, sodas)? ○Daily ○ Weekly ○Occasionally ○Never

If so, how much? _____

Do you eat preprocessed, packaged, or restaurant food? ○Daily ○Weekly ○Occasionally ○Never

If so, how much? _____

Do you eat foods containing gluten? ○ Daily ○ Weekly ○Occasionally ○ Never

If so, how much? _____

Do you eat processed (non-organic) dairy products? ○ Daily ○Weekly ○ Occasionally ○ Never

If so, how much? _____

How would you rate your level of stress (on a scale of 0-10)? 0 1 2 3 4 5 6 7 8 9 10

Explain: _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

_____

_____

Please list any <u>allergies to medications</u>: _____

_____

_____

Please list all medications and their purpose :_____

_____

_____

_____

Please list any health conditions not mentioned:_____

_____

_____

Please list all past surgeries: _____

_____

_____

Please list all accidents and falls: _____

_____

_____

LINCOLN WELLNESS CENTER
RELEASE THE HEALING WITHIN

Terms of Acceptance

When a person seeks Chiropractic care, and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.
Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnoses, or treatment for those findings we recommend that you seek another healthcare provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)
All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ Date: _____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
If you agree, sign below.

Signature: _____ Date: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant, and the doctors and staff of Lincoln Wellness Center have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature: _____ Date: _____

LINCOLN WELLNESS CENTER

RELEASE THE HEALING WITHIN

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient Date

LINCOLN WELLNESS CENTER
RELEASE THE HEALING WITHIN

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Lincoln Wellness Center. Please provide the necessary health care providers or persons who may need to be consulted if related to the patient's condition. They include:

1. _____

2. _____

3. _____

4. _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."
A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.
Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may influence any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.
Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

_____ _____

Signature Date

For Office Use Only:

Signed form received by: _____