Confidential Patient Information

Coulee Health
920 WI-16 Suite A
West Salem, WI 54669

(608) 612-0777 Phone
(608) 807-5142 Fax
www.couleehealth.com

Date:_____/_____/_____

Patient's Full Name _____

Parent/Guardian (s) Full Name(s) _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____

Number of Siblings/Ages_____

How did you find us?

- ☐ Existing Patient Name:_____
- ☐ Physician Name:_____
- ☐ Friend Name:_____
- ☐ Other_____
- ☐ Office Website
- ☐ MPI Website
- ☐ Other Website:_____
- ☐ LaCrosse Chamber
- ☐ Google:_____
- ☐ Social Media (i.e. Facebook)

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Family Physician: _____ City: _____ State:_____ Phone_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Chiropractor's Name / Location _____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Coulee Health, Spine and Bodyworks, LLC) are **paid in full**.

Parent/Guardian Signature:_____ **Date:**_____/_____/_____

Dear Parent/Guardian: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe this child will respond satisfactorily, we will not accept your case. THANK YOU.

Pregnancy & Birth

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Birth Weight _____ Birth Length _____ Age of Mother @ baby's birth _____

Infant's gestational age: □ Full Term □ Preterm If so, # of weeks _____ □ Post-term

Apgar scores (if known) _____

Type of Delivery: □ Vaginal □ C-section If so, please explain in space provided below.

Initial feeding of baby: □ Breast □ Bottle If bottle, was breast feeding attempted □ Yes □ No

Name of Midwife or Obstetrician / Place of birth / City / State _____

Were there any complications with the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor, c-section)? □ Yes □ No
If yes, explain _____

_____

_____

Were there any problems/complications during labor? □ Yes □ No
If yes, explain _____

_____

_____

Were there any problems/complications/trauma with mother or baby first year postpartum? □ Yes □ No
If yes, explain _____

_____

_____

What are your primary movement concerns for baby (i.e. rolling over, walking) _____

_____

_____

_____

_____

_____

Please list the movement history for baby (i.e. milestones hit and when) _____

_____

_____

_____

_____

_____