



9780 Lantern Road, Suite 230, Fishers, Indiana 46037

## A BRAIN-BASED, FAMILY WELLNESS CENTER

ON A SCALE OF 1 - 10, PLEASE RATE YOURSELF BELOW

Your current level of health:	1 2 3 4 5 6 7 8 9 10
Your current level of pain:	1 2 3 4 5 6 7 8 9 10
Your interest in reducing stress:	1 2 3 4 5 6 7 8 9 10
... getting fit:	1 2 3 4 5 6 7 8 9 10
... eating better:	1 2 3 4 5 6 7 8 9 10
... improving sleep:	1 2 3 4 5 6 7 8 9 10
... improving posture/mobility:	1 2 3 4 5 6 7 8 9 10
...improving brain function:	1 2 3 4 5 6 7 8 9 10
... improving quality of life:	1 2 3 4 5 6 7 8 9 10
... learning about wellness:	1 2 3 4 5 6 7 8 9 10

### PERSONAL INFORMATION

Full Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Yes, I want to receive appt reminders via text. Cell Phone Carrier: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ # of Years: \_\_\_\_\_

Type of Work Performed: \_\_\_\_\_

Marital Status: *Single Partnered Married Widowed Divorced*

Spouse's Name (if applicable): \_\_\_\_\_ Number of Children: \_\_\_\_\_

Please share how you were referred to our office:     Google     Facebook     Website     Friend

If referred by a friend, Please provide their name so that we can thank them \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

PHYSICAL HEALTH HISTORY

Name of previous chiropractor: \_\_\_\_\_

Length of time under care: \_\_\_\_\_

What is/are your present health concern(s)? When did you first notice this issue?

Concern	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How have these issues affected your life?  
\_\_\_\_\_  
\_\_\_\_\_

Please list any traumas, accidents, major injuries, surgeries or hospital stays with approximate dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your oral health (past/present)?  
\_\_\_\_\_  
\_\_\_\_\_

(YES/NO) Have you ever been in a motor vehicle accident? \_\_\_\_\_  
*If yes, please describe the incident, including the date(s) :* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CHEMICAL (NUTRITIONAL) HEALTH HISTORY:

Describe your typical meal for ...  
Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_

Approximately how much water do you drink daily? \_\_\_\_\_

Please list any supplements or prescriptions (including antibiotics) that you are currently taking, and how long you have been taking them (If you need more space, please write on the back of this page):  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your bowel movements and urine:

	Bowels	Urine
Frequency	_____	_____
Color	_____	_____
Consistency	_____	

EMOTIONAL HEALTH HISTORY:

Please circle "Y" for yes, "S" for sometimes, and "N" for no.

<i>I love myself.....</i>	Y	S	N
<i>I am satisfied with my life.....</i>	Y	S	N
<i>I enjoy my job.....</i>	Y	S	N
<i>I tend to have great relationships.....</i>	Y	S	N
<i>I am a steward of my own health and well being.....</i>	Y	S	N
<i>I spend time in prayer and/or meditation on a daily basis.....</i>	Y	S	N
<i>I adapt well to change.....</i>	Y	S	N
<i>I listen to my body's messages.....</i>	Y	S	N
<i>I actively practice stress management.....</i>	Y	S	N
<i>I have a regular exercise schedule.....</i>	Y	S	N

LIFESTYLE HEALTH HISTORY:

Describe your childhood family life :

\_\_\_\_\_

Describe your childhood activities that may have caused your body stress (involved in sports? daredevil tendencies? Violin lessons? etc. :

\_\_\_\_\_

How many siblings do you have, and where are you in line? \_\_\_\_\_

Please circle all that apply to your current lifestyle:

- |                                       |  |                             |
|---------------------------------------|--|-----------------------------|
| <i>Enjoy regular time with Nature</i> | <i>Extended lengths of time sitting/standing</i> | <i>Labor Intensive</i>      |
| <i>Regular Detox/Cleansing</i>        | <i>Reading Ingredients Labels</i>                | <i>Travel Often</i>         |
| <i>Community Involvement</i>          | <i>High-Stress Responsibilities</i>              | <i>Financially Stressed</i> |

BRAIN HEALTH HISTORY

Please circle all that apply:

- |                    |                    |                             |
|--------------------|--------------------|-----------------------------|
| Poor Attention     | Migraines          | Cold Hands/Feet             |
| Impulsive          | Headaches          | Tight Muscles               |
| Easily Distracted  | Vertigo            | Teeth Grinding              |
| Disorganized       | Seizures           | Irritable Bowel             |
| Depressed          | Sleepwalking       | Heart Palpitations          |
| Lacking Motivation | Hot Flashes        | Restless Sleep              |
| Poor Concentration | PMS                | Poor Expression of Emotions |
| Spaciness          | Food Sensitivities | Poor Immune System          |
| Constipation       | Bed Wetting        | Racing Mind                 |
| Low Pain Threshold | Eating Disorder    | High Blood Pressure         |
| Difficulty Waking  | Bipolar Disorder   | Accelerated Aging           |
| Worry              | Mood Swings        | Anxiety                     |
| Irritable          | Panic Attacks      | Other: _____                |

### FOR FEMALES ONLY

(Y/N) Do you experience menstrual pains? \_\_\_\_\_ *If yes, is the pain during your cycle or ovulation?* \_\_\_\_\_

When was your first menses? \_\_\_\_\_ Number of pregnancies? \_\_\_\_\_

(Y/N) Do you have Children? \_\_\_\_\_ *If yes, what are their names and ages?* \_\_\_\_\_

Did you experience complications with any of your pregnancies or delivery? \_\_\_\_\_

(Y/N) Have you had a cesarean birth? \_\_\_\_\_

(Y/N) Have you begun menopause? \_\_\_\_\_ (Y/N) *If yes, have you completed menopause?* \_\_\_\_\_

*If yes, describe your transition through menopause.* \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, AT PRESENT, I AM NOT PREGNANT AND I HEREBY RELEASE STILLPOINT FAMILY CHIROPRACTIC AND RADIOLOGICAL STAFF FROM ANY AND ALL RESPONSIBILITY OR LIABILITY UPON MY BEING X-RAYED FOR THE PURPOSE OF DIAGNOSTIC EVALUATION.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

### DAILY STRESSORS

Please circle all that apply:

#### PHYSICAL STRESSORS

Sitting  
Driving  
Lack of Sleep  
Unsupportive Pillow/Mattress  
Poor Sleep Posture  
Poor Standing Posture  
Repetitive Movements  
Lack of/Unbalanced Exercise  
Daily Activities  
Past Injuries  
Past Surgeries  
Overweight  
Dehydration  
Flat Feet/Foot Support Imbalance  
Purse/Wallet/Bookbag  
Carry Kids on Hip  
Birth Trauma

#### CHEMICAL STRESSORS

Pollution/Allergens  
GMO's  
Malnutrition  
Artificial Sweeteners  
Artificial Food Coloring  
Additives/Preservatives  
Pesticides/Herbicides  
Tap Water  
Prescription Drugs  
Vaccines  
Cosmetics/Perfumes  
Hygiene Products  
Cleaning Products  
Aluminum Foil/Plastic Storage  
Smoke  
Caffeine

#### EMOTIONAL STRESSORS

Anger/Fear  
Anxiety/Worry  
Depression/Grief  
Overwhelmed  
Unemployed  
Dislike Career  
Divorce/Break-Up  
Relational /Family Stress  
Financial Burden  
Peer Pressure  
Time Constraints  
Bullying  
News Media  
Addictions  
Exhaustion  
Traffic

PATIENT POLICY AGREEMENT

Appointments with Dr. Pennella are scheduled according to the program of care that she feels is best for you. This customized program will consists of three stages - Relief Care (relief from pain), Corrective Care (maintaining stability), and Wellness Care (prevention). Depending on where you begin, multiple adjustments will be scheduled for you in a concentrated amount of time, followed by exam(s) to monitor your progress. As you improve and your health stabilizes, you will graduate into the next stage of care. After completion of the initial program, a consultation will be scheduled to re-evaluate your stage of care, and to outline a new, customized program including health goals, accountability, and wellness education.

**If you are unable to keep an appointment, we require that you inform us with 48 hours notice.** Stillpoint Family Chiropractic reserves the right to charge \$50.00 for missed appointments, or for those appointments cancelled without a 4 hour notice. **In order to achieve best results, every cancelled appointment must be made up within 1 week.** Following the schedule that Dr. Pennella outlines for you is of paramount importance. We ask that each patient assume the responsibility of strict adherence to the appointment schedule as it is designed for optimum results.

When entering the office on any given visit, please go directly to the front desk and sign-in. We sincerely attempt to honor all appointments at the scheduled time. If you are late, or expect to be late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call/text you in advance, and advise you on the status of your appointment time. If you have any questions regarding our office policies or your appointments, please do not hesitate to ask.

At Stillpoint Family Chiropractic, we strongly support patient education. We also believe that increasing your level of health is a team effort. As Dr. Pennella is a doctor of *brain balance*, you are a doctor of *choices* - on a daily basis, you have the opportunity to decide whether your choices will contribute positively or negatively to your health. We look forward to creating a partnership with you to work towards achieving all your health goals.

**I agree to make a full and honest effort towards meeting my health goals.**

\_\_\_\_\_  
Patient Signature

WELLNESS ORIENTATION WORKSHOP - WOW! CLASS

Attending WOW is required as part of your program of care. The purpose of requiring all new patients to attend is to encourage and enlighten our patient's understanding about the connection between the body's health, a well-balanced nervous system, and what YOU can do to achieve brain balance outside the office.

We encourage everyone to bring a guest to this workshop for personal support. We also encourage you to talk about your health experiences in this office! Sharing your story in person or on social media often results in introducing chiropractic and SFC to many in need who may not have considered it before. You are always welcome to bring anyone to a WOW class in the future as a first step in their journey towards learning about wellness and brain-based care; check with the front desk for scheduling.

**I will attend a WOW class hosted by Stillpoint Family Chiropractic.**

\_\_\_\_\_  
Patient Signature

## FINANCIAL POLICY

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are expected at the time of service, or at the end of each week. Patient balances are not to exceed \$200 at any time.

Returned checks and balances over 30 days may be subject to additional fees and interest charges of 1.5% per month, as well as attorney fees and any court costs related to the collection of these fees.

In terms of insurance, this office is recognized as an "out-of-network" office; we do not participate in any network. This does not mean that your insurance does not cover services rendered in this office, but that coverage is based on Out-Of-Network benefits. It is the responsibility of the patient to contact their insurance company to determine their benefits and eligibility.

Excluding all Medicare patients, Stillpoint Family Chiropractic is not responsible for the billing of services to insurance companies. Upon request of the patient, Super-Bills (patient billing) will be printed listing all services and payments made. The responsibility of sending this super-bill to the insurance company for the purpose of billing relies on the patient. Super-bills may be requested at any time.

For patients who comply with Dr. Pennella's program of care outlined on page 5, payment plans will be offered for financial assistance.

**I agree to pay Stillpoint Family Chiropractic, Inc. for services rendered by using one of the following payment methods (please place a ✓ by one of the following):**

- PRIVATE PAY (payment is made by cash, check or credit card)
- Payment is made in full at the time of service unless other arrangements have been agreed upon with Dr. Pennella.
  - Payment plans; see office manager.
- MEDICARE (65 years of age and/or enrolled in Medicare; beginning 10/01/2009, the patient will pay Medicare rates at the time of service, and be reimbursed directly by Medicare after the deductible has been met.
- Stillpoint agrees to complete and file all usual and customary medical claims.
  - Patient agrees to pay any amount determined by Medicare to be the patient's responsibility.
- PERSONAL INJURY (automobile or other liability injury)
- Patient must provide Stillpoint Family Chiropractic with information on the accident and insurance carrier of the faulty party.
  - Alternate payment information must be submitted for coverage through MedPay Clause of patient's automobile insurance, or patient's health insurance, or both.
  - PATIENT IS RESPONSIBLE FOR PAYMENT IN FULL, REGARDLESS OF COVERAGE THROUGH ANY OF THE METHODS ABOVE.
  - Patient is required to pay for services until Med Pay or faulty party payment is confirmed, at which time payments will be credited to the patient.

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Patient signature

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Date