 VENN CHIROPRACTIC

& WELLNESS CENTER

File Number: \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt./Suite: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle One: OPT IN or OUT for text message appointment reminders via the cell phone number you provided\*\*

In Case of Emergency:

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How did you find out about our office? And whom may we thank for referring you to us?

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**Terms of Acceptance**

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only three goals: to LOCATE, ANALYZE, and CORRECT spinal interference within the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (Spinal misalignment producing nerve interference) in and of itself, does NOT allow the body to function at its optimal level. Chiropractic allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

**We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of these condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, having read the above statement, and understanding it fully, do undertake Gonstead Chiropractic health care on these basis.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a minor:**

I authorize the doctors at Venn Chiropractic & Wellness Center to care for my child. I have read and understand the term of acceptance and agree to them.

Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that I am personally responsible for all fees and charges. I understand that payment is due at the time services are rendered. I understand that any third party payer may choose not to reimburse me for the cost of any health care procedure. I understand that if my third party payer chooses not to reimburse me for any reason, including but not limited to a deductible not being met, I am personally responsible for all fees and charges. I understand that a $25 charge will be applied to all returned checks. I understand that any reconciliation or adaptation of fees are at the discretion of the Chiropractor and is to be kept confidential between the chiropractor and myself. I agree to receive important information regarding my chiropractic care via email, phone or mail. By signing I understand and agree to the above financial agreement.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consultation History**

What is your main complaint?

Date when symptom first appeared: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BELOW, Please CIRCLE the option that best answers the following questions.

Origination? Gradual Sudden Overtime

Severity? Mild Moderate Severe

Problem Side? Left Right Bilateral (both)

Frequency? Constant Frequent Intermittent Occasional

Pain Intensity (1-10), 10 being the worst: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain your type of pain: (ex: aching, throbbing, sharp, burning)

What caused this illness/pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the problem worse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CIRCLE the following: My pain is worse in the: MORNING AFTERNOON EVENING NIGHT

Numbess or Tingling? Circle: YES NO

If yes, please explain where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the pain radiate? Circle: YES NO

If yes, please explain where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN: ARE YOU CURRENTLY PREGNANT? (CIRCLE ONE) YES NO**

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**Medical History**

**FAMILY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **How many?** | **Back?** | **Heart?** | **Stroke?** | **Cancer?** | **High BP?** | **Diabetes?** |
| **Mother:** | **-** |  |  |  |  |  |  |
| **Father:** | **-** |  |  |  |  |  |  |
| **Sisters:** |  |  |  |  |  |  |  |
| **Brothers:** |  |  |  |  |  |  |  |
| **Children:** |  |  |  |  |  |  |  |

**SOCIAL**

**(Check each box that applies to you)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Daily** | **3x/wk** | **2x/wk** | **1x/wk** | **2x/mo** | **1x/mo** | **Never** |
| **Standing:** |  |  |  |  |  |  |  |
| **Sit at a desk:** |  |  |  |  |  |  |  |
| **Work on a**  **Computer:** |  |  |  |  |  |  |  |
| **Work on the phone:** |  |  |  |  |  |  |  |
| **Moderate/**  **Heavy labor:** |  |  |  |  |  |  |  |
| **Stay at home:** |  |  |  |  |  |  |  |
| **Deliver packages:** |  |  |  |  |  |  |  |
| **Tobacco/**  **Smoke:** |  |  |  |  |  |  |  |
| **Alcoholic beverages:** |  |  |  |  |  |  |  |
| **Caffeine:** |  |  |  |  |  |  |  |
| **Exercise:** |  |  |  |  |  |  |  |

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**SURGICAL**

|  |  |
| --- | --- |
| **Surgery(s) Performed:** | **Date of Performance:** |
|  |  |

**ALLERGIES**

|  |  |
| --- | --- |
| **Description:** | **Date Detected:** |
|  |  |

**CURRENT MEDICATIONS**

|  |  |
| --- | --- |
| **Medication:** | **Reason for use:** |
|  |  |

**PRE-EXISTING CONDITIONS LIST**

**(Please check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * **Addiction** | * **Colitis** | * **Heart Disease/Attacks** | * **Lung Disease** | * **Liver Issues** |
| * **Asthma** | * **Depression/**   **Anxiety** | * **Heart Murmur** | * **Mental Disorder** | * **Sickle Cell** |
| * **Anemia** | * **Diabetes** | * **Hemorrhoids** | * **Osteoporosis** | * **Stroke** |
| * **Arrhythmia** | * **Eating Disorder** | * **Hepatitis** | * **Paralysis** | * **Suicidal Thoughts** |
| * **Arthritis** | * **Emphysema** | * **High/Low Blood Pressure** | * **Pneumonia** | * **Thyroid Disease** |
| * **Blood Disorder** | * **Epilepsy** | * **High Cholesterol** | * **Polio** | * **TB** |
| * **Bowel Problems** | * **Gall Bladder Disease** | * **HIV/AIDS** | * **Prostate Problems** | * **Abnormal Urine** |
| * **Broken Bones** | * **Genital Herpes** | * **Joint/Back Pain** | * **Reflux/Ulcers** | * **Migraines** |
| * **Cancer** | * **Glaucoma** | * **Kidney Infection** | * **Rheumatic Fever** | * **Allergies** |
| * **Cataracts** | * **Gout** | * **Kidney Disease/Stones** | * **Seizures** | * **Vascular Disease** |
| * **Chicken Pox** | * **Headaches** | * **Liver Disease** | * **Sexual Dysfunction** | * **Blood Clot** |

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**Agreement of Treatment**

On every visit after determining what is necessary for your care, a spinal adjustment (98943) and or an extra spinal adjustment (98943) will be given.

In addition, in order to increase joint range of motion and to decrease muscle spasm, you will be required to use the massage chair in the changing rooms for mechanical traction (97012) either before or after the treatment with the doctor.

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and agree to receive and participate in the above treatments.**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HIPAA Agreement**

**Notice\* the following agreement will be read and signed in office.**

**I have read and received the notice of privacy practices from Venn Chiropractic and Wellness Center.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Other Services**

**Here at Venn Chiropractic, we aim to accommodate ALL of your wellness needs!**

**Are you interested in gaining more knowledge about our other services/products we offer?**

**(Check all that apply)**

* **Massage**
* **Whole food supplements**
* **Physical Therapy**