WILSON FAMILY CHIROPRACTIC

14511 N Santa Fe
Edmond, OK 73013
405-242-4911

"The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in proper diet, and in the cause and prevention of disease."
Thomas Edison

Personal Information

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Email Address _____

☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced Spouse/Partner's Name _____

# of Kids ____ How many at home? _____ Names & ages: _____

_____

What kind of work do you do? _____ Self-employed? ☐ Yes ☐ No

Have you ever been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State: _____ Good results? ☐ Yes ☐ No

Are you under care of any other doctor? Yes/No If Yes, the condition being treated for: _____

Please check if you are here for any of the following: ☐ Motor Vehicle Injury ☐ Work Injury ☐ Other Injury

Whom may we thank for referring you to our center? _____

Favorite hobbies or interests: _____

Women Only: Are you pregnant? Yes Due Date:_____ No

Let's Find Out Why You're Here…

Reason for seeking chiropractic care: _____

_____

Any other specific concerns? _____

List all current medications and conditions being treated: _____

_____

List any past surgeries and dates: _____

List any past accidents/injuries and dates: _____

_____

Have you ever been under chiropractic maintenance care? _____

Do you know what a subluxation is? If yes, please describe: _____

_____

Quality of Life Inventory

If you have experienced any of the following, please indicate by writing C (Current), P (Past) or CP (Current and Past).

___ Fatigue	___ Neck pain/stiffness	___ Loss of balance	___ Lights bother eyes
___ Sleeping problems	___ Shoulder pain	___ Earaches	___ Cold Sweats
___ Frequent colds	___ Mid back pain	___ Ringing in ears	___ Fever
___ Asthma	___ Low back pain	___ Irritability	___ Skin Conditions
___ Allergies	___ Hip pain	___ Depression	___ Urinary problems
___ Digestion problems	___ Joint pain	___ Nervousness	___ Mood swings
___ Weakness	___ Chest Pain	___ Tension	___ Menstrual irregularity
___ Dizziness	___ Heart problems	___ Ulcers	___ Menstrual pain
___ Headaches	___ Pins/ needles in legs	___ Pin/needles in arms	___ Hot flashes
___ Migraines	___ Leg/foot pain	___ Arm/hand pain	___ Brain fog
___ Nausea	___ Numbness in toes	___ Numbness in fingers	___ Difficulty focusing
___ Fainting	___ Cold feet	___ Cold hands	___ Cancer
___ Low energy/tired	___ Anxiety	___ Sinus congestion	Other:_____

What are the Top ***THREE*** things you would hope to achieve while pursuing Chiropractic Care?

1.

2.

3.

Stress Survey

Please review each of these common stresses and circle when you experienced it in your life. Use P for Past and C for Current. If you expect or anticipate the possibility of experiencing this stress in the future, circle F for Future.

Physical		Mental		Chemical	
Forceps delivery	P C F	Divorce of parents or spouse	P C F	Take prescription medication	P C F
Falls of any type	P C F	Death of a loved one	P C F	Take over-the-counter drugs	P C F
Broken bones	P C F	Serious illness (self or loved one)	P C F	Consume alcohol	P C F
Strains or sprains	P C F	Financial concerns	P C F	Consume caffeine	P C F
Bad posture	P C F	WORRY	P C F	Use tobacco products	P C F
Poor sleeping habits	P C F	Work environment	P C F	Eat fast foods	P C F
Repetitive movements	P C F	Relationships	P C F	Use artificial sweeteners	P C F
Sports injuries	P C F	Anger by you or at you	P C F	Bad diet (white flour & sugar)	P C F
Heavy lifting or bending	P C F	Feel "not worthy"	P C F	Environmental pollution	P C F
Overweight	P C F	Put things off to the last minute	P C F	Overweight	P C F
Other_____	P C F	Other_____	P C F	Other_____	P C F

Do you notice you store your stress in (please circle):

♦ Your neck/shoulders ♦ Mid-back ♦ Low-back/pelvis ♦ Other_____

Please rate your GENERAL stress level, 0 to 10 _____ At Work/School _____ At Home ____

Your Health

Name/Phone of the last doctor who put you on a health development program?

_____

Were you able to stay on the program? _____ How long? _____ Good results? _____

Are you healthier today than you were 5 years ago? ☐ Yes ☐ No ☐ Not Sure

Will you be as happy and healthy as you are today (or BETTER) in 5 years? ☐ Yes ☐ No ☐ Not Sure

If yes, what will you do to make sure you are? _____

If no or not sure, what *could* you do to *start* getting happier & healthier? _____

_____

What would you like your health to be like 5 years from now? _____

_____

Let's Make Sure We're On the Same Page…

When an individual or family seeks and is accepted into a program of function-based chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

While the natural result of optimal function *is* increased health, wellness and an overall improved quality of life, we will not treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Joshua to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Wilson to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed_____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!

Patient Name:_____D.O.B.:_____Date:_____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of electricity, traction, motion, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____

Witness Signature: _____

Patient Name: _____ D.O.B.:_____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need. If you are pregnant, or expected to be, please mark through this portion.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state “Signature on File”. Box 12 Reads as follows: “PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.” Box 13 Reads as follows: “INSURED’S OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.”

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____ Signature of Parent or Guardian: _____