EXCEL FAMILY CHIROPRACTIC & WELLNESS, INC. **Acct#**_____
820 Geneva Pkwy N, Ste 105
Lake Geneva WI 53147
Phone: 262-248-6700 Fax:262-248-6764 Email:frontdesk@excelfamilychiro.com

PatientName:_____ **Date:** _____

Address_____ City/State_____ ZipCode_____

Home.Phone_____ Cell:_____ Work._____

EmailAddress:_____ Sex: **M** **F** (*Please circle*) Date ofBirth:_____

Referredby: _____

Have you ever received chiropractic care? (*Please circle*) **Yes** **No** If yes,when? _____

Name of mostrecentChiropractor:_____

Health History:

1. Previous Injury orTrauma:

2. Have you ever broken any bones?Which?

3. Allergies:

4. Medications:

5. Surgeries:
   Date Type ofSurgery
   _____
   _____
   _____

Family Health History:

Do you have a family history of? (*Please indicate all that apply*)
□ Cancer □Strokes/TIA's □Headaches □Cardiacdisease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □Diabetes
□ Other_____ □ None of theabove

Social and Occupational History:

Job description:
_____

Level of Activity? (*Pleasecheck one)* _____High_____Medium ____Low

Any alcohol, tobacco or drug use: **Yes** **No***(Pleasecircle)* **Frequency** _____per day weekmonth

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Review of Systems(*Please check all that apply)*

- □ Anemia
- □ Asthma
- □ Bladder Infection
- □ Congestive Heart Failure
- □ Constipation
- □ COPD
- □ Depression
- □ Diabetes
- □ Dialysis
- □ Difficulty Swallowing
- □ Emphysema
- □ Frequent Abdominal Pain
- □ Gastro Esophageal Reflux
- □ Gout
- □ Heart Attack/MIs
- □ Heart Surgery
- □ Hepatitis or Liver Disease
- □ Hiatal Hernia
- □ HIV Positive
- □ Hormone Replacement Therapy
- □ Hypertension
- □ Irregular Heartbeat
- □ Irritable Bowel/Colitis
- □ Kidney Disease
- □ Loss of Sense of Smell
- □ Metal Implants
- □ Murmurs or Valvular Disease
- □ Osteoarthritis
- □ Pacemaker
- □ Pancreatic Disease
- □ Psychiatric Diagnosis
- □ Renal Calculi/Stones
- □ Rheumatoid Arthritis
- □ Scoliosis
- □ Seizures
- □ Skin Grafts
- □ Strokes/TIAs
- □ Thyroid Disease
- □ Tremors
- □ Ulcerative Disease
- □ Vertigo
- □ Visual Changes/Loss of Vision

Other: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with State of Wisconsin statutes.

Patient orGuardianSignature_____Date_____

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PATIENT SYMPTOM FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Primary Symptom:

1. Exact Location (right, left, front, back,etc.) _____

2. When did the symptombegin? _____

   - o Did the symptom begin suddenly or gradually? *(please circleone)*
   - o Describe how the symptombegan?_____
   - o Describe the quality of the symptom (circle all thatapply):
     Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
     _____

3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most ofthe time: 1 2 3 4 5 6 7 8 910

4. What percentage of the time you are awake do you experience the above symptom at theaboveintensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95100

5. Does the symptom radiate to another part of your body (*please circle one*): Y**es No**
   - o If yes, where does the symptomradiate? _____
   - o Is the symptom worse at certain times of the day or night? *(pleasecircle)*
     Morning Afternoon Evening Night Unaffected by time ofday

6. What makes the symptom worse? *(please circle all thatapply):*
   - o Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left orright, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:

     _____

7. What makes the symptom better? *(please circle all thatapply):*
   - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers,nothing,
   - o Other *(pleasedescribe):*

     _____

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Secondary Symptom:

1. Exact Location (right, left, front, back,etc.) _____

2. When did the symptombegin? _____

    - Did the symptom begin suddenly or gradually? *(please circleone)*
    - Describe how the symptombegan?_____
    - Describe the quality of the symptom *(please circle all thatapply):*
      Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
      _____

3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most ofthe time: 1 2 3 4 5 6 7 8 910

4. What percentage of the time you are awake do you experience the above symptom at theaboveintensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95100

5. Does the symptom radiate to another part of your body (*please circle one*): Y**es No**
    - If yes, where does the symptomradiate? _____
    - Is the symptom worse at certain times of the day or night? *(pleasecircle)*
      Morning Afternoon Evening Night Unaffected by time ofday

6. What makes the symptom worse? *(please circle all thatapply):*
    - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left orright, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describebelow:

      _____

7. What makes the symptom better? *(please circle all thatapply):*
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers,nothing,
    - Other *(pleasedescribe):*

      _____

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HIPAA NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT FOR TREATMENT

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry ourtreatment, payment or health care operations for other purposes that are permitted or required by law. Your "Protected Health Information" is information pertaining to you, including your demographic information that may identify you and that is related to your past, present, or future physical or mental health or condition and related careservices.

Use and Disclosures of Protected Health Information:
Your Protected Health Information may be used and disclosed by your chiropractor, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, request and receive payment for your health care bills, to support the operations of this chiropractic practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, yourhealthcareinformationmaybeprovidedtoaphysicianorhealthcarefacilitytowhomyouhavebeenreferredtoensure that the physician or facility has the necessary information to diagnose or treatyou.

Payment: Your Protected Health Information will be used as needed, to obtain payment for your health care services from your insurance company or insurance representatives.

Informed Consent for Chiropractic Treatment: We may disclose, as needed, your Protected Health Information in order to support the business activities of this office. Some of these activities may include, but not limited to:

1. Quality assessment activities; training of chiropractic office personnel, marketing, and fund raisingactivities in and outside theoffice.
2. We may ask for your permission to use your photograph for promotions or activities within ouroffice.
3. We may contact you regarding your appointment and/or account, using text alerts, phones messages andemails.
4. I (patient) give us consent to the performance of chiropractic spinal manipulations/adjustments and otherprocedures, which may include an examination, spinal x-rays, massage therapy, kinesiotaping, at the Doctor's discretion and as part of my spinal careplan.
5. I(patient) understand that my spinal manipulations will be performed in a semi-private setting. If I requestadditional privacy, this office will try to accommodateme.
6. I (patient) may revoke this authorization, at any time, in writing, except to the extent that your chiropractor orthe practice has taken an action in reliance on the use or disclosure indicated in theauthorization.
7. If my insurance is billed, I authorize payment of medical benefits directly to Excel Family Chiropractic &Wellness, Inc. for servicesperformed.

We are happy to provide a copy of this information for your review, please let us know.

_____ _____
Signature of PatientorRepresentative Date

_____
Printed Name

_____
Minor Child Name: (if applicable)

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my healthcare and medical services providers and payors to disclose and release my protected health information described below to:

Name	Phone Number	Relationship

Health Information to be disclosed upon the request of the person named above (Circle A or B):

A. **Disclose my complete health record** (included but not limited to diagnoses, prognosis, treatment, billing, appointment times)
B. **Disclose my health record**, as above, **BUT** do not disclose the following:
   - o _____
   - o _____
   - o _____

This authorization shall be effective until (Circle A or B):

A. All past, present, and future periods
B. Date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers)

Print Name _____

Signature _____

Date of Birth _____

Date _____

Note: HIPAA Authority for Right of Access: 45 C.F.R § 164.524
Resource provided by the ABA Commission on Law and Aging www.americanbar.org/aging