Chiropractic Wellness Center
It's more than feeling better... it's being healthier.

New Patient Welcome Packet

Patient Information

Name: ____
Last First MI Prefer to be called

Phone: ______________________________ Email address: ____________________
Cell Work

Mailing Address: ____________________ City: ______________ State: _____ Zip: ________

Whom may we thank for referring you? ____

How would you like to receive appointment reminders? ☐ Phone ☐ Email ☐ Text

If choosing "Text" please tell us you Phone Provider (Verizon, AT&T, etc.): ____________________

May we send you our e-newsletter to inform you of special offers and health information? ☐ Yes ☐ No

Date of Birth: ______________ Sex: ☐ Male ☐ Female Age: ________ SS#: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Do you have children? ☐ Yes ☐ No How many? __________

Occupation: ______________________________ Employer: ______________________________

Employer Address: ______________________________ Phone: ______________________________

Emergency contact: ____________________ Relation: ______________ Phone: ______________

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other

Has it been reported? ☐ Yes ☐ No If yes, to whom? ______________________________

Financial Information

Person responsible for this account: ____

Relationship to patient (if other than self): ______________________ Phone: ________________

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: ______________________________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: ______________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (Insured Patients)

I certify that I (or my dependent) have insurance coverage with ____________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, CHIROPRACTIC WELLNESS CENTER, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Signature: ______________________________ Date: ______________

Health History

What is your current weight: ____________ lbs., and height: ______ ft. ______ in.

Who is your primary care physician? (doctor and/or practice) ______________________________________

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Scarlet Fever
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Stroke
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Suicide Attempt
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Thyroid Problems
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tonsillitis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Tumors/Growths
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Typhoid Fever
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Ulcers
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Bronchitis
☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Venereal Disease	☐ Bulimia
☐ Gout	☐ Multiple Sclerosis	☐ Whooping Cough	☐ Heart Disease	☐ Mumps
☐ Severe allergy to chicken		☐ Other ______________________		

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain ____________________

List Medications/Supplements Below:

Name Dosage Frequency Reason for medication

1.____
2.____
3.____

Please list any surgeries and/or hospitalizations you have had (type & date):

1.____
2.____
3.____

Allergies? (circle) If so, please list below:

Drug Allergies Food Allergies Seasonal Allergies

1.____
2.____
3.____

If you circled Food or Seasonal Allergies, are you interested in treating them? ☐ Yes ☐ No

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Health History *(Continued)*

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Subjective Questionnaire

What is your primary reason for seeking care?

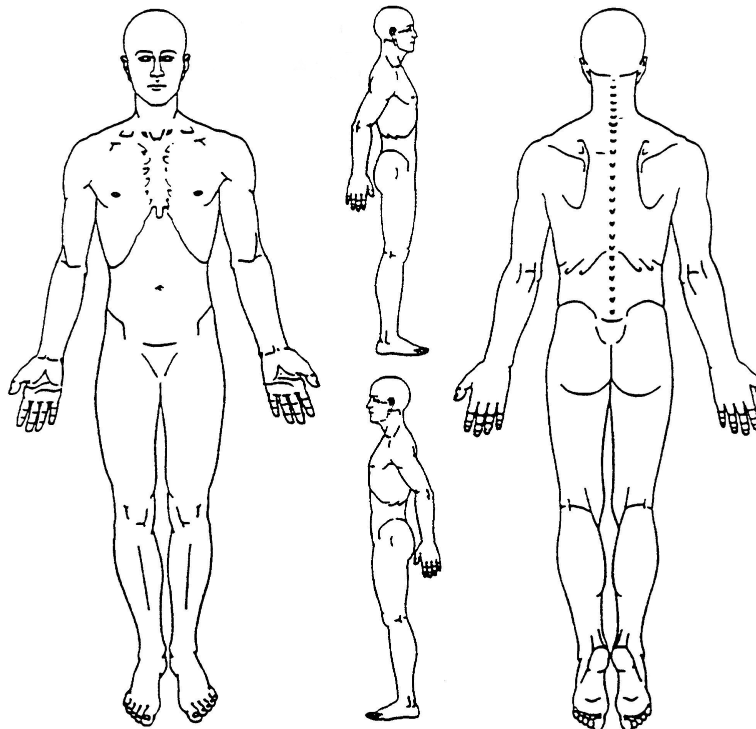
☐ Neck Pain ☐ Hand Pain ☐ Headaches ☐ Back Pain
☐ Foot Pain ☐ Migraines ☐ Knee Pain ☐ Shoulder Pain
☐ Hip Pain ☐ Scoliosis ☐ Sciatica
☐ Abnormal Sensation in the Extremities ☐ Other ____________________________

Rate your pain on a scale of 1-10 (1 being *little to no pain* and 10 being *extremely painful)*

1 2 3 4 5 6 7 8 9 10

Please mark the figure below with:

Muscle Spasm = S Burning = B Ache = A Numbness = N Pins & Needles = P



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Subjective Questionnaire (Continued)

How would you best describe your symptom(s)?

☐ Aching	☐ Sharp	☐ Stabbing	☐ Radiating
☐ Dull	☐ Burning	☐ Throbbing	☐ Numbness
☐ Difficulty Walking	☐ Constant	☐ Intermittent	☐ Hypersensitive
☐ Muscle Cramp/Spasm	☐ Decreased ROM	☐ Tingling	☐Other ____________________

Please describe the frequency of your symptoms: ____

Approximately how long ago did you first notice the symptoms: ____

Is there anything that you can associate with the onset of your symptoms? (Example: injury, lifestyle, health condition, habits): ____

How would you describe the onset of your symptoms: ☐ Sudden ☐ Gradual

How would you describe the progression of your symptoms since the onset:

☐ Progressively Worse	☐ Progressively Better	☐ Off and On	☐ Increasing Frequency
☐ Same Frequency	☐ Decreasing Frequency	☐ Moved	☐ _________________________

What or when do your symptoms seem the worse?

☐ Sitting	☐ Sleeping	☐ Transition sit to stand	☐ Bending	☐ Computer Work
☐ Exercise	☐ End of Day	☐ Morning	☐ Lifting	☐ Up and Down Stairs
☐ walking	☐ Other ______________________			

What seems to decrease your symptoms?

☐ Rest/Sleep	☐ Sitting	☐ Exercise/Stretching	☐ Medication	☐ Heat	☐ Ice
☐ Acupuncture	☐ Topical Meds/Oils	☐ Change Position	☐ Chiropractic	☐ Other ____________________	

Have you tried any of these treatment in the past? ☐ Yes ☐ No If Yes, any of the following?

☐ Stretching	☐ Chiropractic	☐ Physical Therapy	☐ Medication	☐ Acupuncture	☐ Heat
☐ Injections	☐ Massage	☐ Topical Meds/Oils	☐ Exercise	☐ Injections	☐ Ice

Please provide the names of the medication (both over-the-counter and/or prescription) that you have tried:

____

Have you received any recent diagnostic testing related to your symptoms? ☐ Yes ☐ No If Yes, any of the following?

☐ MRI ☐ X-Ray ☐ Vision Test (Headaches) ☐ NCV/EMG ☐ CT Scan

Do you have any numbness/tingling in the pelvic region or unintentional loss of bowel/ bladder control? ☐ Yes ☐ No

X-ray Questionnaire: For women only

Our consultation and examination may indicate x-rays are necessary. If so, please confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time.
☐ Yes, I am definitely pregnant.
☐ No, I am definitely not pregnant at this time.
☐ I request that films not be taken because:
Date of last Menstrual Period: ______________________
____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: ________________________________ Date:__________________

Consent to Care

I hereby authorize the providers to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injections and diagnostic testing. I realize the goal of integrated healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees to that he/she is responsible for all bills incurred at this office.
I agree to settle any claim or dispute I may have against or with any of these persons or entities. Whether related to the prescribed care or otherwise it will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

"National Supplier Clearinghouse Medicare DMEPOS Supplier Statement"

DMEPOS suppliers have the option to disclose the following statement in order to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by supplier legal business name or DBA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

I have read and understand the foregoing. I agree that moving beyond the Free Consultation may entail taking x-rays. If that service is not covered by your insurance, the cost is *$49.00*. You will also need to meet with a nurse practitioner for evaluation. If that service is not covered by your insurance, the cost is $99.*00*.

Patient Signature: ________________________________ Date:__________________

HIPAA Notice of Privacy Practices

This Notice Describes How Medical Information About You May be Used and Disclosed and How You Can Get Access to This Information. Please Review it Carefully.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation of the physician's 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Fore example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to that health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support that business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or engaging for other business activities. For example, we may disclose your protected health information to a chiropractic student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Users and Disclosures: Under the law, we may make disclosures to you and when required by the Secretary and the Department of Heath and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of or use is a civil criminal or administrative action or proceeding, and protected health information that is subject to law may protect access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us normal use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is not in your best interest to permit use and disclosure of your protected health information; your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively. I.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request to amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to review an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Heath and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This document was published and becomes effective on/or before June 1st 2007.

Name: _______________________________ Date: _________________
(printed)

Signature: ____________________________________ Witness: ___________________________
Adult Patient, Parent/Guardian, or Spouse

Patient Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices of Chiropractic Wellness Center.

Please initial one of the following options and sign below:

__________ I wish to receive a paper copy of Privacy Notice.

__________ I wish to receive an electronic copy of Privacy Notice.

Email: ___________________________ @_____________________________

__________ I **do not** request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

__________ I acknowledge that it is the policy of Chiropractic Wellness Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Tammy Giles, about my concerns.

Name: ________________________________ **Date:** _________________
(printed)

Signature: _____________________________________ **Witness:** ____________________________
Adult Patient, Parent/Guardian, or Spouse