Chiropractic Wellness Center, P.C.

Patient Data **Date** ____

First Name _____ Middle Initial ____ Last Name _____
Address Line 1 _____
Address Line 2 _____
City _____ State _____ Zip Code _____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____
Cell Phone (_____) _____-_____Email _____
Date of Birth _____/_____/_____ Sex: □ Male □ Female
Social Security Number: _____-_____-_____ Occupation:_____
How did you hear about our office? _____

Emergency Contact

Contact Name _____ Relationship to Patient _____
Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Insurance

Who is responsible for this account?_____Relationship to Patient:_____
Insurance Co._____Group#_____Policy#_____
Additional Insurance Co._____Group#_____ Policy#_____
Subscriber's Name, Birthdate & SS#:_____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Who is your primary care physician?_____
Date and reason for your last doctor visit:_____
Are you receiving care from any other health professionals?_____yes_____no If yes, please name them and their specialty:_____

Surgeries: (Check all that apply to you)

□ Appendectomy □ Cardiovascular procedure □Cervical spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (Check all that apply to you)

□ Eggs □ Fish and Shellfish □ Milk or Lactose □ Peanuts
□ Soy □ Sulfites □ Wheat/Glutens □ Other _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling	Stroke:	Parent	Sibling
Cancer:	□ Parent	□ Sibling	Thyroid:	Parent	Sibling
Diabetes:	□ Parent	□ Sibling	Other:_____		
Heart Disease	□ Parent	□ Sibling	_____		
Hypertension	□ Parent	□ Sibling	_____		

Occupational Activities: (Check one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper

□ Other _____

Medications & Supplements:_____

_____

Traumas: Physical Injury History

Have you ever had significant falls or other injuries as an adult?___yes___no (if yes, please explain)

_____

_____

Notable childhood injuries:___yes___no (if yes, please explain)_____

_____

Youth or college sports?___yes___no

Auto Accidents:___yes___no

Exercise frequently:___yes___no

Sleep posture:___back___side___stomach Wake up___refreshed and ready___stiff and tired

Are you pregnant? Yes_____ No _____N/A_____

What health condition(s) bring you into our office?_____

_____

_____

What would you like to gain from chiropractic care?

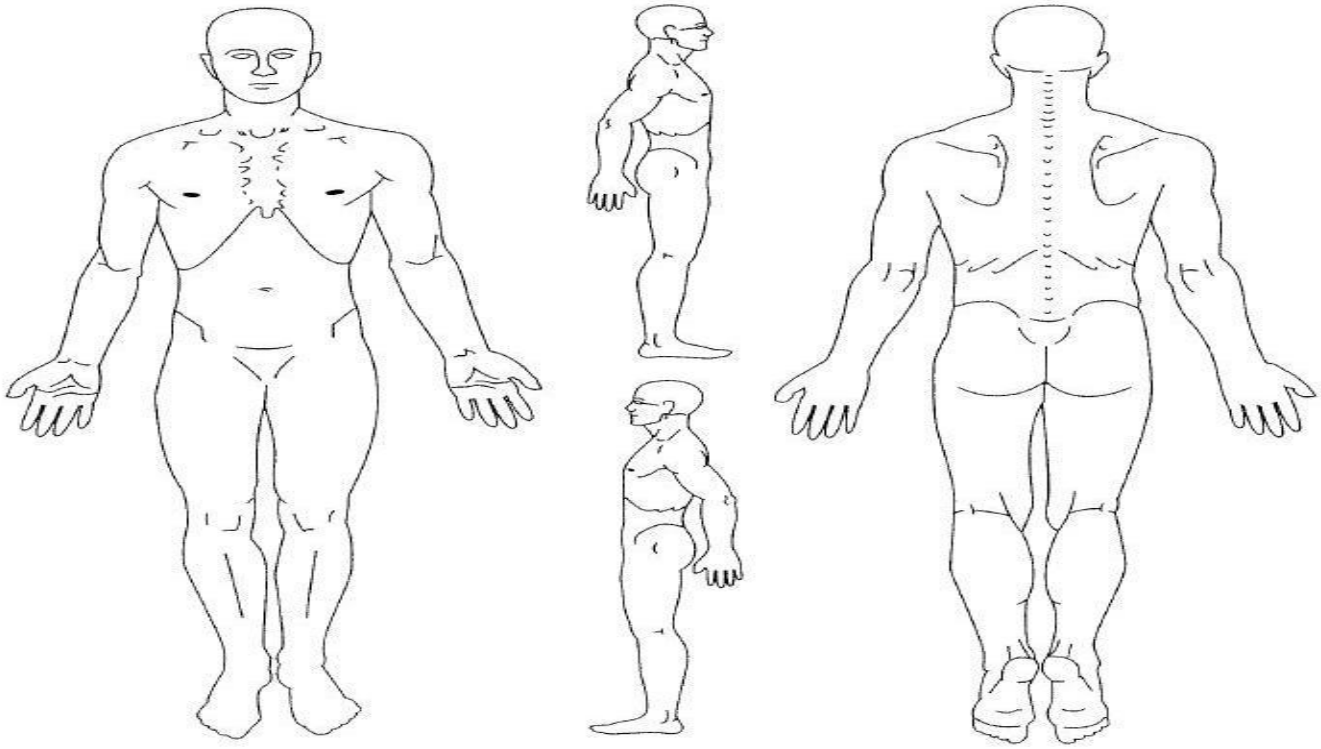
____Resolve existing condition(s)	____Overall wellness
____Flexibility/Strength	____Weight Loss
____Nutritional Counseling/Functional Medicine	____Anti-Aging
____Hormone Help	

Other:_____

Please mark below which figure accurately represents the severity of your symptoms:

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

How did the problem(s) start:___suddenly___gradually___post-injury

Have you received care for your symptoms before?___yes___no

If yes, please explain:_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

_____

How did your symptoms begin? _____

_____

_____

Do your symptoms radiate (travel) to other areas of your body?___yes___no

If so, where?_____

What makes your symptoms better?_____

Worse?_____

Is this condition___getting worse___improving___intermittent___constant___unsure

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date_____

Consent for Treatment of a Minor (if applicable)

I (We) being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Dr. Maycock to administer such treatment deemed advisable, necessary, or requested on the above minor.

I (We) agree to hold Dr. Maycock free and harmless from any claims, suits for damages or complications which may result from such treatment.

_____

Print Name

_____ _____

Signature of Parent/Guardian **Date**

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Kim Maycock all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorized the use of my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by insurance. These charges must be paid as determined by Chiropractic Wellness Center. Legal Fees and/or collection costs are also my responsibility.

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 this state's statutes.

Signature of Patient, Parent, Guardian, or Personal Representative

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Please Print name of Patient, Parent, Guardian, or Personal Representative

Date:_____Relationship to Patient:_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physiotherapy, physical medicine, acupressure, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to:

fractures, disc injuries, dislocations, bruising, muscle strain, diaphragmatic paralysis, infections, bleeding, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke and death.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor of chiropractic to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

X_____ _____

Signature of Patient Date

X_____ _____

Signature of Representative (if patient is minor or handicapped) Date

X_____ _____

Witness to Patients' Signature Date