Spine and Wellness Center, LLC

Patient Information Form

Today's Date ___/___/_____

Title(please circle) Mr. Ms. Mrs. Miss. Dr. Rev. Prof. Other

Last Name _____ First Name_____

Address_____ City_____ State_____ Zip_____

Phone (Home)_____ Phone(Cell)_____Phone(Work)_____

Email address_____

Sex M F	Married Single Widowed Divorced	Date of Birth / /	Social Security Number - -
Patient' s Employer's Name_____ Address_____ City_____ State_____ Zip_____ Phone_____ Occupation_____		Employed Full Time Part Time Retired Not Employed Student Full Time Part Time	

Spouse's Name_____ Spouse's Employer_____

No. Children_____

How did you hear about our office? (please circle)

Family Friend Internet Yellow Pages Drove By Physician Insurance Plan

Insurance: Please provide your current insurance card to the receptionist and we will verify it to see if covers chiropractic.

Automobile Accident/Worker's Compensation Only

Insurance Company_____ Claim #_____Policy #_____
Address_____ City_____ State_____ Zip_____
Adjusters Name_____ Phone_____
Attorney's Name_____ Contact Name_____
Address_____City_____ State_____ Zip_____
Phone_____

In case of Emergency:

Who should we contact:_____ Phone:_____
Relationship:_____

Please List Medical Doctors:

_____ Phone:_____
_____ Phone:_____
_____ Phone:_____

Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature_____ Date_____

Patient Health History

Are you taking any of the following medications? (please circle)

Pain Medication (including aspirin) Muscle Relaxers Anti-Inflammatory Muscle Relaxers
Blood Thinners Insulin Other_____

1. Have you ever had pain like this before? YES/NO
   If yes, please explain:_____

2. Was the injury accident related? ____Auto ____Work When?_____

3. Has your condition affected your daily activities? YES/NO
   If yes, please explain:_____

4. Have you lost work days? YES/NO How many?_____

5. Has there been any changes in your bodily function? YES/NO
   If yes, please explain:_____

6. Name other Doctors you have seen for this condition:_____

7. What surgeries have you had in the past?_____
   _____

8. What are your health goals?_____
   How do you expect to achieve these goals?_____

Do you: (please circle) Take Supplements Exercise Smoke - How much per day_____ Special Diet
Are you wearing: ____Heal Lifts ____Sole Lifts ____Inner Soles _____Arch Supports
What is the age of your mattress?_____

Please mark if you have had any of these symptoms in the last 12 months

( ) Fractured Bones	( ) Neck Pain or Stiffness **R/L**	( ) Numbness, tingling, pain in Buttocks, legs, feet or toes **R/L**
( ) Auto Accidents ____ 0-1 years ago ____ 1-5 years ago ____ 5 or more	( ) Numbness, tingling, Pain in Arms, Hands, Fingers **R/L**	( ) Difficulty in Excessive Standing, Sitting, Riding, Bending' Lifting, or Twisting **R/L**
( ) Foot Trouble **R/L**	( ) Chest Pain, Asthma	( ) Heart Problems
( ) Jaw Pain or Click(TMJ) **R/L**	( ) Other accidents or falls	( ) Stroke
( ) High/Low Blood Pressure	( ) Arthritis	( ) Shoulder pain **R/L**
( ) Diabetes	( ) Varicose Veins	( ) Liver Trouble
( ) Convulsions, Epilepsy	( ) Dizziness	( ) Gall Bladder Trouble
( ) Skin Problems	( ) Ringing in Ears **R/L**	( ) Digestive Problems
( ) Cancer	( ) Hearing Loss **R/L**	( ) Ulcers
( ) Frequent Colds, Flu	( ) Blurred or Double Vision **R/L**	( ) Hemorrhoids
( ) Depressed	( ) Upper Back Pain or Stiffness	( ) Prostate Problems
( ) Irritable	( ) Lower Back Pain or Stiffness	( ) Impotence
( ) Anemia	( ) Pain with Cough, Sneeze	( ) Kidney Problems
( ) Allergy or Sinus Problems	( ) Hip Pain **R/L**	( ) Menstrual Problems, PMS
( ) Under Stress	( ) Headaches	( ) Pregnant Now
( ) Eating Disorder		( ) Taking Birth Control
( ) Trouble Sleeping		( ) Ear Infections
( ) Learning Disability		( ) AIDS, HIV
( ) Mood Changes	( ) Other	( ) Bedwetting

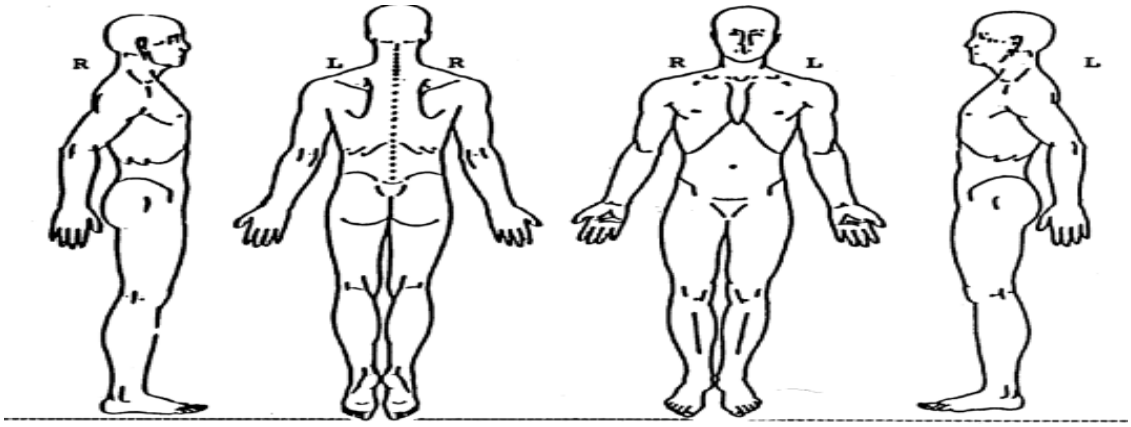
Family Health History:_____
_____

CHIEF COMPLAINT

Patient Name_____ Date _____

What is your Major Complaint _____

Site Please Circle Location of Your Pain



1. Do you have any other health problems that concern you?
2nd Complaint: 2._____
3rd Complaint: 3._____
4th Complaint: 4._____

Onset
1. When did complaint start? Date_____ GRADUALLY / SUDDENLY
2. Did anything cause or contribute to the onset? YES / NO
If yes please explain:_____
_____
_____

Provoking & Palliative
1. What makes your condition worse? _____Nothing _____Lifting _____Trying to Stand _____Standing _____Walking _____Sitting _____Movement _____Exercise _____Inactivity _____Work Activities
Other_____

2. What makes your condition better? _____Nothing _____Standing _____Walking _____Sitting _____Movement _____Exercise _____Inactivity _____Lying Down _____Sleep _____Hot Shower _____Stretching Other_____

Quality
1. Describe the sensation you feel.(Sharp, Dull, Burning, Throbbing, Etc)_____
_____
2. Please rate your Pain. No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain

Radiating
1. Does your pain radiate to any other part of your body? Y/N Do you experience Numbness/Tingling? Y/N
If yes pleases explain:_____

Timing
1. Is your pain Constant – YES / NO Since when:_____
2. Is your pain Intermittent – YES / NO Freguency_____Times Per Week_____Hrs/Days

Terms of Acceptance/Consent to Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of is by specific adjustment of the spine.

Potential Risks: *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.* While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprains/strains, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further Acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I, _____, have read and fully understand the above statement. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

_____ _____
Patient Signature Date

Consent to evaluate and adjust a minor child (for treatment of a child under 18yrs).

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Parent Signature Date

POLICIES

- All first visit charges are payable when services rendered unless other arrangements have been made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Spine and Wellness Center, LLC will prepare all necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Spine and Wellness Center, LLC will be credited to my account upon receipt. *However*, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

Patient Signature:_____ Date:_____

Guardian Signature Authorizing Care:_____ Date: _____