Wellness Choice

# PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____

# WELLNESS CONSULTATION HISTORY

Patient's Name _____ Date_____

Who referred you to our office? _____

If you're going to be well, healthy, what's the #1 thing to fix?_____

How long have you had this problem?_____

What finally motivated you to get this problem handled after so much time? _____

How often does this currently bother you? _____

Who in your family has the same or similar problem? _____Who else?_____

Before you began to suffer with this problem, what type of accident, injury or condition happened to you that may be related to this problem? _____

What have you tried to do to get rid of this problem? _____

After all the things you've tried, how do you <u>feel</u> about the fact that the problem still exists? _____

When it's at its worst, what's that like? _____

When it's like that, how does that make <u>you feel</u>? _____

*Compare a day with the problem at its worst to one without the problem?* _____

How does it affect your work?_____

How does it affect your family life? _____

How does it affect your daily activities? _____

How does it affect your social life? _____

How does it affect your sleep? _____

Is it getting worse? _____ _____ Are you afraid of it getting worse? _____

*When it's at its worst, how much older (incapacitated) does this problem make you feel?*_____

Do you think something needs to change? _____ What? _____

If we find the problem and if we prove that we can fix it together, on a scale of 1-10, rate your commitment to getting rid of this problem: _____

*Is getting rid of this problem and what caused it, a top priority?* _____

Is there anything else that I need to know about your health that I didn't ask? _____

Do you have children? _____ Names _____ Age _____

_____ _____

_____ _____

_____ _____

How's their health? _____

What kind of health problems (earaches, allergies, cold, and headaches) do they have? _____

# PATIENT APPLICATION SURVEY

Full Name _____ Today's Date _____

Date of Birth _____ Age _____ Gender F M Marital Status S M W D

Email _____ Height _____ Weight _____ Shoe Size _____

Address _____ City _____ Zip _____

Home Phone _____ Social Security _____

Cell Phone _____ Occupation _____

Emergency Contact _____ Employer Name _____

Emergency Phone _____

Who Should We Thank for Referring You to Wellness Choice Center? _____

## PURPOSE OF THIS VISIT

| Health Issue | Date Condition Started | Frequency | Severity (0-10) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |

Do you know why/how this condition(s) started? _____

Are these conditions getting worse? ❑ Yes ❑ No Is this: ❑ Constant ❑ Frequent ❑ Occasional ❑ Activity Related

Any previous car accidents or major injuries? _____

How would you describe your pain / discomfort (check all that apply)

❑ Dull ❑ Achy ❑ Throbbing ❑ Stiff ❑ Sharp ❑ Stabbing ❑ Shooting

❑ Intense ❑ Burning ❑ Constricting ❑ Other (please describe) _____

Does your condition interfere with:

❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine (please describe) _____

What activities aggravate your symptoms?

❑ Coughing ❑ Sneezing ❑ Bearing Down ❑ Lifting ❑ Bending ❑ Pushing ❑ Pulling

❑ Driving ❑ Sitting ❑ Walking ❑ Running ❑ Standing ❑ Laying Down ❑ Movement

Is there anything, which has relieved your symptoms? ❑ Yes ❑ No

❑ Ice ❑ Heat ❑ Massage ❑ Resting ❑ Exercise ❑ Sitting ❑ Standing

❑ Bracing/Taping ❑ Stretching ❑ 'Popping' Joints ❑ Laying ❑ Other _____

## PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? ❑ Yes ❑ No If yes, where ? _____

Do you experience numbness and tingling anywhere? ❑ Yes ❑ No If yes, where? _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? ❑ Yes ❑ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

| | | |
|---|---|---|
| Did your previous chiropractor take before and after x-rays? | ❑ Yes | ❑ No |
| Did you know posture determines your health? | ❑ Yes | ❑ No |
| Are you aware of any of your poor posture habits? | ❑ Yes | ❑ No |
| Are you aware that a weakened core can contribute to back pain and poor posture? | ❑ Yes | ❑ No |
| Are you open to core strengthening as part of your rehabilitative program? | | |
| Are you aware of poor posture habits in your spouse or children? | ❑ Yes | ❑ No |

Please Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck? ❑ Yes ❑ No

## HEALTH LIFESTYLE

Do you exercise? ❑ Yes ❑ No How often? 1x 2x 3x 4x 5x per week Other: _____

What activities? ❑ Running/Walking ❑ Weight Training ❑ Cycling ❑ Yoga/Pilates ❑ Other: _____

Do you smoke? ❑ Yes ❑ No How much? _____

Do you drink alcohol? ❑ Yes ❑ No How much/week? _____

Do you drink coffee? Yes ❑ Yes ❑ No How many cups/day? _____

Do you take any supplements? (i.e. vitamins, minerals, herbs) _____

**Health Conditions**

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called forward head syndrome (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

## HEALTH LIFESTYLE (continued)

**CERVICAL SPINE (NECK)**

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

- ❑ Neck Pain
- ❑ Thyroid Conditions
- ❑ TMJ/Pain/Clicking
- ❑ General Fatigue
- ❑ Headaches/Migraines
- ❑ Sinusitis
- ❑ Dizziness
- ❑ Insomnia
- ❑ Allergies/hay fever
- ❑ Hearing disturbances
- ❑ Visual disturbances
- ❑ Low Metabolism
- ❑ Recurrent colds/flu
- ❑ Weakness in grip
- ❑ Coldness in hands
- ❑ Difficulty Losing Weight
- ❑ Pain into your shoulders /arms/hands
- ❑ Numbness/tingling in arms/hands

**THORACIC SPINE (UPPER BACK)**

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- ❑ Heart palpitation
- ❑ Heart murmurs
- ❑ Asthma/ wheezing
- ❑ Tachycardia
- ❑ Shortness of breath
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Pain on deep inhalation / exhalation

**THORACIC SPINE (MID BACK)**

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract and affect these parts of your body. Do you experience:

- ❑ Mid back pain
- ❑ Nausea
- ❑ Indigestion/heartburn
- ❑ Pain into your ribs/chest
- ❑ Ulcers/gastritis
- ❑ Hypoglycemia
- ❑ Acid reflux
- ❑ Tired/irritable after eating or when you haven't eaten

**LUMBAR SPINE (LOW BACK)**

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

- ❑ Pain into your hips/legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Numbness/tingling in your legs/feet
- ❑ Recurrent bladder infection
- ❑ Coldness in your legs/feet
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in your legs/feet
- ❑ Menstrual irregularities/cramping (females)
- ❑ Constipation/diarrhea
- ❑ Sexual dysfunction
- ❑ Low back pain
- ❑ Weak core

Please list any health conditions not mentioned: _____

Please list any medication/surgeries: _____

## MEDICAL HISTORY

Do you or any one in your family been diagnosed with any of the following:

| | | | |
|---|---|---|---|
| ❑ Diabetes | ❑ Varicose Veins | ❑ Neurological Problems | ❑ Lung Disease |
| ❑ Rheumatic Fever | ❑ Circulatory Problems | ❑ Stroke | ❑ Heart Murmurs |
| ❑ High Blood Pressure | ❑ Heart Disease | ❑ Cancer | ❑ Osteoporosis |
| ❑ Kidney Disease | ❑ Seizures | ❑ Migraine | ❑ Headaches |
| ❑ Liver Disease | ❑ Metal Implants | ❑ Infectious Disease | ❑ Gallbladder |
| ❑ Broken Bones/Fractures | ❑ Appendectomy | ❑ Tonsillectomy | ❑ Hernia |
| ❑ Pneumonia | ❑ Polio | ❑ Tuberculosis | ❑ Anemia |
| ❑ Whooping Cough | ❑ Chicken pox | ❑ Mumps | ❑ Measles |
| ❑ Thyroid | ❑ Small Pox | ❑ Influenza | ❑ Pleurisy |
| ❑ Arthritis | ❑ Epilepsy | ❑ Difficulty Urinating | ❑ Eczema |
| ❑ Gout | ❑ Prostate | ❑ Glaucoma | ❑ AIDS |

Current Medications:

Over the counter medication (please list) _____

Prescription medication (please list) _____

Others/supplements (please list) _____

Please list any medication you are allergic to _____

Please list any allergies and reactions: (include dietary allergies) _____

| Previous surgeries (all type) | Approximate date |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

## PRIMARY CARE PHYSICIAN INFORMATION

Doctor's Name _____ Specialty _____

Address _____ City _____ Zip _____

Telephone _____ Last Date of Visit _____

In order to provide complete and wholesome care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize Wellness Choice to contact your physician, request medical records, and/or co-manage your healthcare needs.

_____

Patient's Name (Please Print) Date Patients Signature

_____

Minor's Name (Please Print) Date Guardian's Signature

# AUTHORIZATION & PRIVACY

**AUTHORIZATION CARE**

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. The doctor will not be held responsible for any health conditions, or diagnoses which are pre-existing given by another health care practitioner or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

| Patient's Name (Please Print) | Date | Patients Signature |
|---|---|---|
| Minor's Name (Please Print) | Date | Guardian's Signature |

**HEALTHCARE AUTHORIZATION FORM**

THE FOLLOWING AUTHORIZES WELLNESS CHOICE CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Wellness Choice to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I give permission to Wellness Choice to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Wellness Choice permission to use and disclose your protected health information in accordance with the directives listed above.

**ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES**

I, _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent
The right to object to the use of my health care information for directory purpose
The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operation.

| Patient Name | Patient Signature | Date |
|---|---|---|
| Doctor's Name | Doctor's Signature | Date |

Wellness Choice

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND FINANCIAL AGREEMENT**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible by the doctor or intern affiliated with Wellness Choice.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

**Financial Agreement:** I agree that in return for the services provided to me by the Wellness Choice I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Wellness Choice for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy ensuring the patient or any other party liable to the patient is hereby assigned to the Wellness Choice. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Wellness Choice accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a scheduled appointment at Wellness Choice Center, I may be charged a cancellation fee which is at the discretion of Wellness Choice.

**Assignment of Benefits**: I agree that payments intended for the Wellness Choice in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to the Wellness Choice.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Wellness Choice to perform such. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Patient's Signature