Chiropractic Wellness Center

Enhancing the Human Potential

HIPAA Notice of Privacy Practices Acknowledgement

Patient's Name (printed):

Last _____ First _____ MI _____

I have received the HIPAA Notice of Privacy Practices from Chiropractic Wellness Center. I have reviewed it and understand my rights and the policies as they apply.

Signature of patient/legal guardian _____

Legal Guardian's relationship to patient _____

Date 03/05/2014

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Cash Financial Policy

It is the policy of Chiropractic Wellness Center to collect payment for all services rendered at the time of service, unless other financial arrangements are approved.

Our office will gladly accept:

- Cash
- Personal Checks
- Visa / Master Card / American Express / Discover
- Flex / HSA

Your health is our major concern. Our goal is to provide to you the best possible chiropractic care. We will not allow the limitations of your coverage to dictate the quality of the care you receive. If special arrangements are needed, please discuss them with our insurance and billing personnel. Monthly payments plans are available.

I have read and understand the above Insurance and Financial Policy. I understand that the final financial responsibility of this account rests upon myself.

Last _____ First _____ MI _____

Signed _____ Dated: 03/05/2014

Chiropractic Wellness Center

Patient Demographic Form

First Name:_____ MI:_____ Today's Date 03/05/2014 Acct # _____

Last Name:_____

Home# _____

Sex:_____ Date of Birth:_____ Age:_____

Cell# _____

Maritial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email: _____

Social Security# _____
** SSN may be required to process insurance*

Emergency Contact:_____

Address: _____ Phone:_____

City: _____ State:_____ Zip:_____ Relation:_____

Race: ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other _____
☐ I choose not to specify

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ French
☐ German ☐ Other _____ ☐ I choose not to specify

Would you like the following sent to your email?

Appt Reminders: ☐ Y ☐ N

Account Statements: ☐ Y ☐ N

Newsletter: ☐ Y ☐ N

Employment Status: ☐ Employed ☐ Part Time ☐ Full Time Student ☐ Retired ☐ Unemployed

Employer/School:_____ Work#_____

Is it ok to contact you at work? ☐ Y ☐ N

Do you currently smoke tobacco of any kind? ☐ Current everyday ☐ Current Sometimes ☐ Former smoker ☐ No

If yes, Approximately how long? _____ year(s)

How interested are you in quitting?

0 (none) 1 2 3 4 5 (Somewhat) 6 7 8 9 10 (Very)

Has any doctor ever diagnosed you with hypertension? ☐ Y ☐ N

If yes, please briefly discrible treatment: _____

_____

Has any doctor diagnosed you with Diabetes presently? ☐ Y ☐ N

If yes, ☐ Type I ☐ Type II Was the blood lab work for hemoglobin A1c > 9.0% ☐ Y ☐ N ☐ Unknown

Please list any surgeries and/or any hospitalizations: _____

_____

Breifly list any other health problems: _____

_____

List any known allergies you have had to any medications and your reaction to allergen. If None, check here: ☐

	(Allergen)	(Reaction)
1)		
2)		
3)		
4)		
5)		

**If you already carry an allergen list, the front desk will simply make a copy for our records. Thank you.*

List any medications you currently take and the dosage. If None, check here: ☐

	(Medication)	(Dose)
1)		
2)		
3)		
4)		
5)		

**If you already carry a list of Medications, the front desk will simply make a copy for our records. Thank you.*

Chiropractic Wellness Center

Presenting Condition and Health History

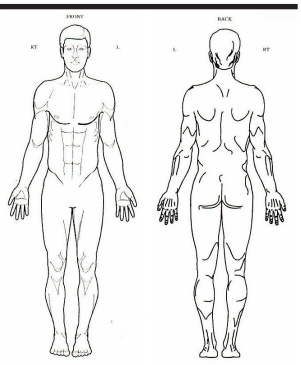
First Name:_____ MI:_____ **Today's Date** 03/05/2014 **Acct #** _____

Last Name:_____

Reason For your Visit: _____ Have you seen a Chiropractor Before? ☐Y ☐N

Who can we thank for your refferal? _____

Place an X on the picture where you continue to have pain, numbness, or tingling.



Rate the intensity of your pain (least) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (most)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How Often do you have the pain?

☐Occasionally (0-25%) ☐Intermittently (25-50%) ☐Frequently (50-75%) ☐Constantly (100%)

Does it interfere with your?

☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____

Activities that reproduce the pain:

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other _____

Is this condition due to an accident? ☐Y ☐N Date _____ ☐Auto ☐Work ☐Other _____

If your condition is due to an accident we would like you to fill out additional information regarding the incident. Please request the appropriate packet if you have not already received one.

As a policy we do not accept third party insurance for auto related injuries. Please ask front desk if you need more information.

Please list the approximate dates for any of the following exams you may have received recently:

Physical Exam _____ Spinal X-ray _____ Dental X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ MRI, CT, Bone Scan _____ Urine Test _____

What treatment have you already received for your condition? ☐None

Medications _____ Date_____ Doctor _____

Surgeries _____ Date_____ Doctor _____

Physical Therapy _____ Date_____ Doctor _____

Chiropracitic Services _____ Date_____ Doctor _____

Are you currently pregnant? ☐Y ☐N Due Date_____

Social Habits:

Smoking (packs/day) _____

Alcohol (drinks/wk) _____

Caffeine (Cups/day) _____

High Stree (Reason) _____

Exercise:

☐None ☐Moderate ☐Daily ☐Heavy

Work Activity:

☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

(brief description & Year)

Falls _____

Head Injuries _____

Broken Bone _____

Surgeries _____

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