Tap Into Wellness Chiropractic Care

Confidential Patient Information

Name_____ _____

Date of Birth_____ Age_____ Gender M or F Marital Status_____ # Children____

Address_____
Address *City* *State Zip Code*

Home Phone #_____ Cell Phone_____

Email_____

_____
Your Occupation *Company Name* *City* *Work Phone*

_____
Spouse or Guardian's Name *Occupation* *Company Name* *City*

How did you hear about us?_____

Do you have health insurance? □Yes □No Company_____

If yes, please present your card(s) to the office manager for processing.

BRIEFLY describe your major complaint(s): _____

_____

Was this condition caused by a work related injury (with claim filed) or automobile accident injury? Yes / No

Please list your family physician: _____

Please list any health care providers you've seen for this condition:

_____

_____

PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS
- □ **Recent accident** such as a fall, whiplash, or blow to the head
- □ Muscle spasms
- □ Numbness or tingling of hands or feet or radiating pain
- □ Headaches
- □ Migraines
- □ Depression
- □ Anxiety
- □ Dizziness
- □ Vision problem
- □ Nausea
- □ Restriction of movement
- □ Sleeping trouble
- □ Asthma or breathing problem
- □ High blood pressure
- □ Hearing problem
- □ Convulsions/epilepsy
- □ Heartburn/Acid Reflux
- □ Digestive trouble
- □ Menstrual problems
- □ Sinus problems
- □ Difficulty with stress
- □ Spinal disorder
- □ Shoulder, arm or hand problem
- □ Hip, Leg or foot problem
- □ Jaw/mouth problem

DIAGNOSED CONDTIONS
- □ Born with bone or joint disorder
- □ Degenerative arthritis
- □ Rheumatoid arthritis
- □ Compression fracture
- □ Heart attack or heart disorder
- □ History of stroke or aneurysm
- □ Cancer
- □ Diabetes
- □ Gout
- □ Lupus
- □ Ankylosing spondylitis
- □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- □ 3 or more months of sterold medications or intravenous drugs (past or present)
- □ Tuberculosis
- □ Hepatitis B or HIV infection
- □ Multiple sclerosis
- □ Thyroid or hormone disorder
- □ Osteoporosis

OTHER CONDITIONS
- □ _____
- □ _____
- □ _____
- □ _____

SPECIFIC PAIN IN THE BODY
- □ Neck pain with difficulty swallowing
- □ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- □ Leg pain that worsens with exercise
- □ Numbness of inner thighs
- □ Back pain with urinary problems
- □ Severe pain that interrupts sleep
- □ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS
- □ Poor balance when walking or standing
- □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- □ Memory loss after injury
- □ Recent, unexplained weight loss
- □ Recent progressive muscle weakness or shaking
- □ Recent or current fever over 102°F
- □ Loss of bowel or bladder control

-Please Continue on Page 2-

NAME:_____

FAMILY HISTORY (Circle) Spine problems / Autoimmune disorders / Arthritis / Cancer / Diabetes / Heart disease Kidney disease / Mental illness / Seizures Other:_____

Last known: Height_____ Weight_____ (If female) **Is it possible you are pregnant?** ▫Yes ▫No

Describe any surgeries or hospitalizations:

Surgeries / Hospital Stays	Date

Please List any Medications you are currently taking:

Name	Reason

How would you rate your diet? ▫ **Excellent** ▫ **Good** ▫ **Fair** ▫ **Poor** ▫ **I don't know**

Do you participate in a regular exercise program? ▫**Yes** ▫**No**

What activities do you do on a regular basis (sitting at computer, manual labor, etc.)?_____

_____

Have you been treated by a chiropractor before? ▫**Yes** ▫**No** **If yes, how long ago?** _____

By signing below, I certify that my medical information above is correct to the best of my knowledge.

_____ _____

Date Patient Signature

-Please Continue to Page 3-

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal, to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. 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 or disappointment.

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

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

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

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. 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 a health care provider who specializes in that area.

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, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore accept Chiropractic care on this basis.

_____ _____
Date Patient Signature

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

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

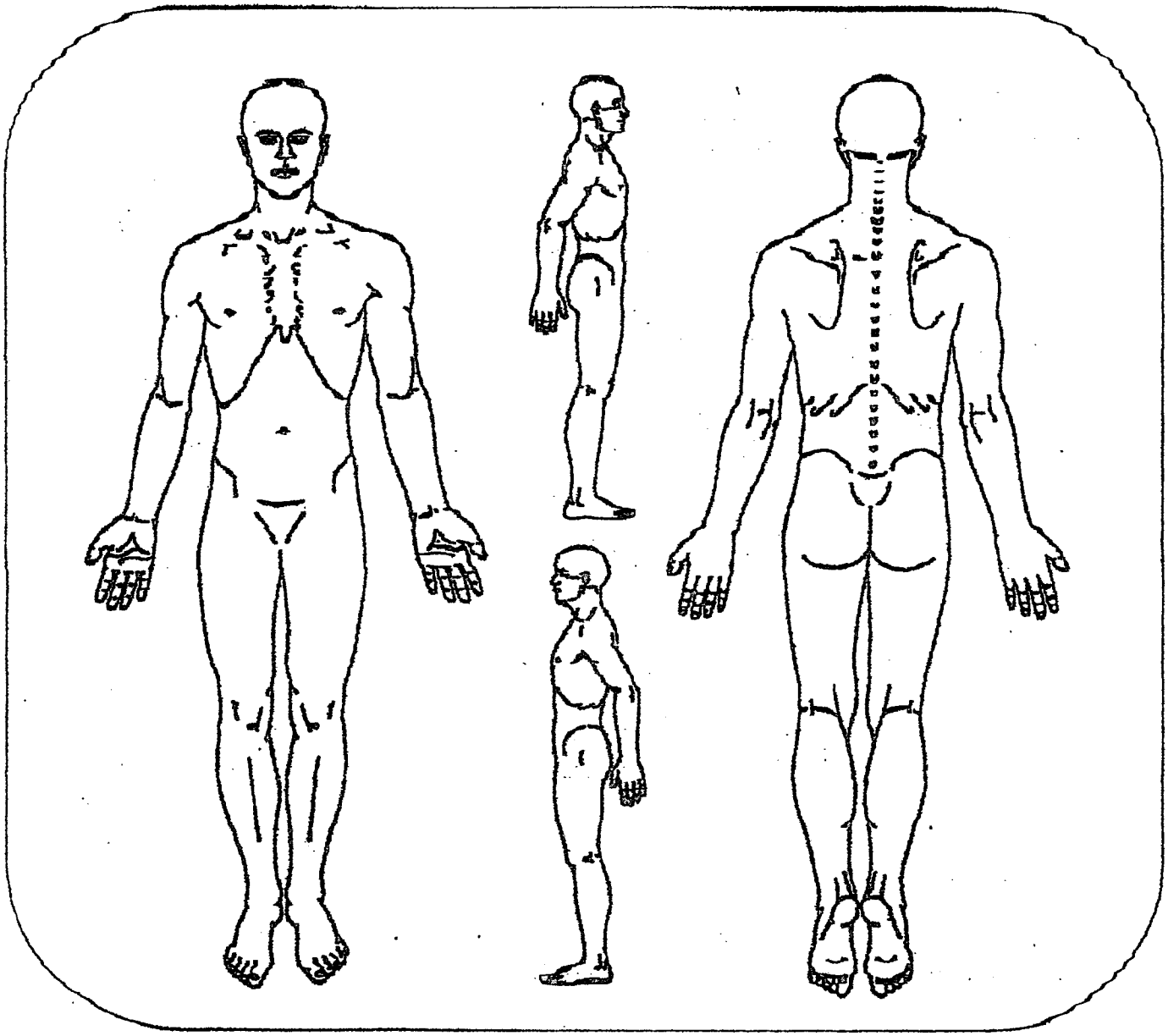
chiropractic care.

TAP INTO WELLNESS

Chiropractic / Acupuncture

"Healing the Mind, Body and Spirit"

PAIN DRAWING



On the diagram above, please mark all areas of pain or discomfort with an "X" or a circle. Next to the mark, list the severity of the symptoms from 0 – 10 (0 being no pain, 10 being severe pain). Also, note the frequency of the symptoms using the following:

O = Occasional F = Frequent C = Constant A = Upon certain activities/movements

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Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

WHAT IS ACUPUNCTURE?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

IS ACUPUNCTURE SAFE?

Acupuncture is generally very safe. Serious side effects are extremely rare – less than one per 10,000 treatments.

DOES ACUPUNCTURE HAVE SIDE EFFECTS?

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients. If affected, you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Existing symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.
- Fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

IS THERE ANYTHING YOUR PRACTITIONER NEEDS TO KNOW?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint or funny turn.
- If you have a pacemaker or any other electrical implants.
- If you have a bleeding disorder.
- If you are taking anti-coagulants or any other medication.
- If you have damaged heart valves or have any other particular risk of infection.

Only the highest quality single-use, sterile, disposable needles are used in this clinic.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature _____ Date _____

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DOCTOR'S NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At this clinic, we have always kept your health information secure and confidential. The law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

WHAT WE (MEDICAL PROVIDER) MAY DO

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without you prior written authorization.

WHAT YOU (PATIENT) MAY DO

You may request in writing that we do not disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the mentioned normal use.

As we will need to contact you from time-to-time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. We require a written request regarding the information you want to see. Also, if you would like a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. This request needs to be submitted in writing along with any statement you would like included in your file. We may or may not make changes requested, but will include your statement in your file. Earlier documents will not be removed, however we will include new information.

You have the right to receive a copy of this notice. Any changes of the details of this notice will be sent to you in writing.

Complaints can be filed with the Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, Washington DC, 20201.

I have received a copy of the Doctor's Office Notice of Privacy Practices.

_____ _____

Signature Date