corner on wellness
CHIROPRACTIC CENTER

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____ City & State: _____

Phone: ( ) _____ Email: _____

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W DP Spouse Name: _____

Number of Children: _____ Children's Ages: _____

Who can we thank for referring you or how did you hear about us? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Corner on Wellness Chiropractic Center?

_____

_____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No How long ago? _____

What is your reason for the change? (if applicable) _____

What health goal, if you were to complete or accomplish it, would have the greatest impact of your life?

_____

_____

MEDICATIONS

□ Anxiety/Depression
□ Blood Pressure
□ Pain Narcotics
□ Muscle Relaxers
□ Migraine/Headache
□ Cholesterol
□ ADD/ADHD
□ Diabetes

□ Other _____

□ Other _____

□ Other _____

VITAMINS/SUPPLEMENTS

□Multi-Vitamin
□ Vitamin D3
□ Fish Oil/Omega -3
□ Probiotics

□ _____

□ _____

□ _____

HEALTH CONCERNS

□ Anxiety/Depression
□ Digestive Troubles
□ Nausea/Vomiting
□ Diabetes
□ Hypertension
□ Arthritis
□ Loss of Balance
□ Neck/Back Pain
□ Pain in Arms/Legs
□ Irritability
□ Fatigue/Sleep Issues
□ Dizziness
□ Ringing in Ears
□ Sensitivity to Light
□ Loss of Concentration
□ Memory Problems
□ Headaches
□ Stiffness/Flexibility
□ Sinus Troubles/Allergies
□ Cold Hands/Feet
□ Other _____

ALLERGIES

List any allergies you have

_____

_____

_____

_____

_____

VITALS

Height: _____ ft. _____ in. Weight: _____ lbs.

LIFESTYLE

Do you exercise? Yes No How often and what type of exercise? _____

Current smoker? Yes No If Yes how much? _____ Former smoker-when did you quit? _____

Do you consume alcohol? Yes No If yes how often? _____

FAMILY HISTORY

Mother living? Y N Cause of death? _____

Father living? Y N Cause of death? _____

EMERGENCY CONTACT

Name: _____

Phone: ( ) _____ Relation: _____

Date: _____ Signature: _____

Functional Rating Index

For use with neck and back problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number which most closely describes your condition right now.

1. **Pain intensity**

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. **Sleeping**

Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. **Personal Care (washing, dressing, etc.)**

No pain No restrictions	Mild pain No restrictions	Moderate pain need to go slowly	Moderate pain need some assistance	Severe pain need 100% assistance

4. **Travel (driving, etc.)**

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. **Work**

Can do usual work plus unlimited extra work	Can do usual work: no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. **Recreation**

Can do all activities	Can do most activities	Can do some activities	Can do a few activities

7. **Frequency of Pain**

No pain	Occasional pain: 25% of day	Intermittent pain: 50% of day	Frequent pain: 75% of day	Constant pain:100% of day

8. **Lifting**

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. **Walking**

No pain: any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. **Standing**

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name _____ **Total Score** _____
PRINTED

_____ _____
Signature **Date**

INFORMED CONSENT

I (We) hereby request and consent to performance of chiropractic adjustments and other Chiropractic procedures on me by Dr. Arthur, Dr. Shay and /or other licensed doctors of Chiropractic who may by employed by or engaged in practice at the Corner on Wellness Chiropractic Center.

I have had the opportunity to discuss with Dr. Arthur, Dr. Shay or other clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that the practice of neither Chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the named procedures.

Date: _____Signature:_____

Minor child: _____ Relationship to child: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices.

A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____ Relationship to Patient: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- I authorize Corner on Wellness Chiropractic Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to Corner on Wellness Chiropractic Center of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Corner on Wellness Chiropractic Center based in whole or in part upon the charges made for services received. I hereby appoint Corner on Wellness Chiropractic Center authority to endorse and cash checks, drafts, or money orders made payable to undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Corner on Wellness Chiropractic Center.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment for non-coverage, deductible, and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies, please ask to speak to our billing specialist. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

  Date: _____ Signature: _____