Patient Application Form

Welcome to Complete Wellness Chiropractic Center! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems. Please fill out the following information completely so the doctor can let you know if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Information

Date: ______/______/________ E-mail____________________________

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Rev. ☐Rank____________________ Nickname____________________

Last Name____________________ First Name____________________ Middle Name____________________

Address____________________ City____________________ State______ Zip____________

Mobile Phone (______)______-________ Home Phone (______)______-________ Work Phone (______)______-________

Gender: ☐M ☐F Marital Status: ☐S ☐M ☐W ☐D SSN: ______-____-______ Date of Birth: _____/_____/______ Age:______

Are you pregnant? ☐Yes ☐No If yes, how many weeks? _____ Children (names, ages) ____________________

Employer Name____________________ Occupation____________________

Spouse Name____________________ Date of Birth: _____/_____/______ SSN:______-____-______

Spouse's Employer ____________________ Occupation____________________ Phone (_____)_____-______

Most of our patients are referred by a family member or friend, how did you hear about our office?

☐ Doctor ☐Friend ☐Family Member Their Name____________________

☐Yellow Pages ☐Website ☐Presentation ☐Sign ☐Newspaper ☐Other____________________

Emergency Contact

Emergency Contact's Name____________________ ☐Spouse ☐Parent ☐Other Phone (______)______-________

Do you give CWCC doctors and/or staff permission to speak with this person or release information to them regarding your treatment? ☐YES ☐NO

Primary Insurance Information

Person responsible for bill: Name:____________________ Date of Birth: ______/_____/______

Address____________________ City____________________ State______ Zip____________

Mobile Phone (_____)______-________ Home Phone(______)______-________ Work Phone(______)______-________

Insurance Carrier: ____________________ ID/Claim #: ____________________ Group/Plan: ____________

Policy Holder: ____________________ Date of Birth _____/_____/_____ S.S.N.: ______-______-______

Phone #: (______)______-________ Effective Date _____/_____/______

It is expected and appreciated that all co-insurance, deductible, and co-payments due are paid at the time services are rendered. Complete Wellness Center does not bill secondary insurances. Please provide us with a copy of your insurance card(s) and your state identification card at time of your visit.

Patient's Signature____________________ **Date** ____________________

Purpose Your Visit

Primary/Main Complaint:______________________________

Is this related to an automobile accident or work injury? ☐Yes ☐No If yes, date of accident: ____/____/______

When did this condition begin?____/____/______ Did it begin: ☐Gradually ☐Suddenly

Describe how your injury occurred: ______________________________

Have you experienced this condition before? ☐Yes ☐No If yes, please explain____________________

Type of pain: ☐Ache ☐Burning ☐Dull ☐Sharp ☐Stiff ☐Throbbing ☐Stabbing ☐Shooting ☐Tingling ☐Tightness ☐Numbness ☐Spasm

Description of pain: ☐Mild ☐Moderate ☐Severe

Rate your current pain level? Cervical pain 0-10: _____ Thoracic pain 0-10: _____ Lumbar pain 0-10: _____ Extremity pain 0-10: _____

Does the pain radiate into your extremities? ☐Yes ☐No If yes, please explain? ____________________

What activities aggravate your symptoms?______________________________

Is there anything that has relieved your symptoms? ☐Yes ☐No If yes, please explain ____________________

Is there anything that has aggravated your symptoms? ☐Yes ☐No If yes, please explain ____________________

Is the condition getting worse? ☐Yes ☐No

Does your complaint interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine

How often do you experience these symptoms throughout the day? ☐100% ☐75% ☐50% ☐25% ☐10% ☐Only with activity

Explain______________________________

Who have you seen for this? ______________________________

What did they do? ______________________________

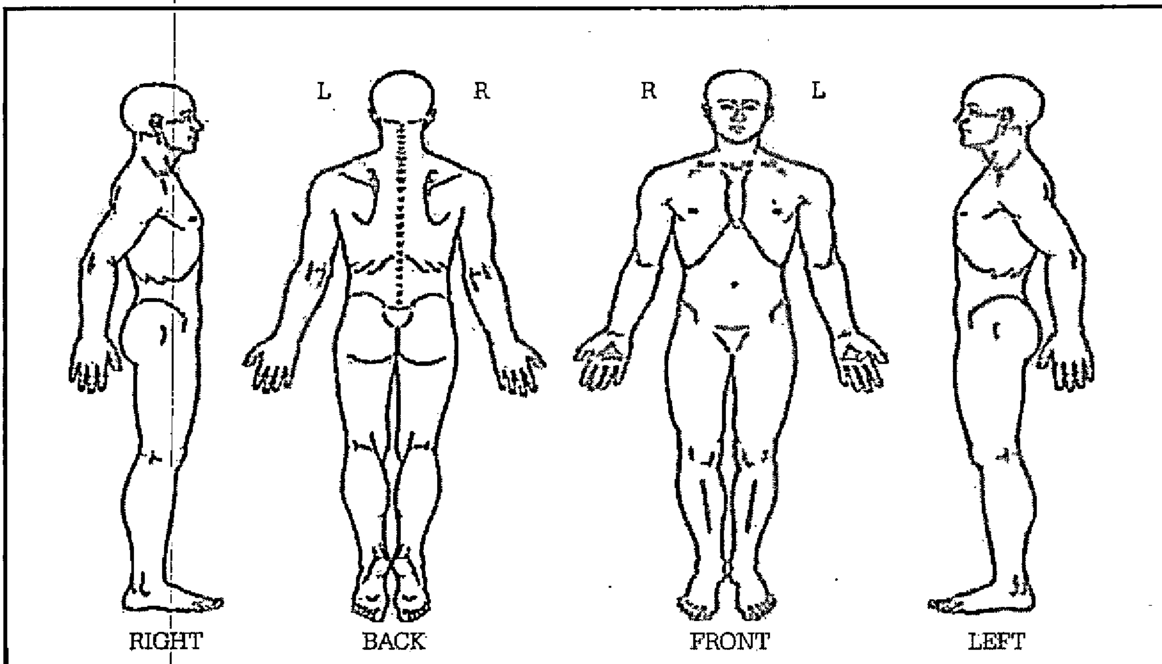
How did you respond? ______________________________

Please list any other complaints:

1. ______________________________
2. ______________________________
3. ______________________________

AREA(S) OF COMPLAINT

Place "Xs" on the area(s) where you have pain and draw lines to where it radiates:



HEALTH LIFESTYLE

Do you exercise? ☐Yes ☐No How often? ☐1X ☐2X ☐3X ☐4X ☐5X per week ☐Other ____________

What activities? ☐Running ☐Weights ☐Cycling ☐Yoga ☐Pilates ☐Swimming ☐Other ____________

Do you smoke? ☐Yes ☐No

If yes, how many packs per day? ______ How long have you been smoking? ____________

Do you drink alcohol? ☐Yes ☐No

If yes, what? ____________ How much? ____________ How often? ____________

Do you drink coffee? ☐Yes ☐No If yes, how many cups per day? ____________

Do you drink soda? ☐Yes ☐No If yes, how many per 12 oz. servings per day? ____________

Do you drink water? ☐Yes ☐No If yes, how much per day? ____________

Do you eat vegetables and fruits? ☐Yes ☐No How many servings of fruit daily? ______ How many servings of vegetables? ______

Do you take any supplements (i.e. vitamins, minerals, herbs)? ☐Yes ☐No

If yes, list the supplements you are taking: ____________

Are you interested in a ***FREE*** nutritional consult? ☐YES ☐NO

EXPERIENCE WITH CHIROPRACTIC

Who was your previous family chiropractor? Name: ____________

Address: ____________ Phone Number: (______)______-______

When was your last visit? ____________

Reason for your treatments? ☐Wellness Care ☐Acute Care

What were your symptoms? ____________

What treatments were given? ____________

How did you respond? ____________

Did your previous chiropractor take before and after x-rays? ☐Yes ☐No

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Did you know your posture has a significant effect on your health? ☐Yes ☐No

Are you aware of any of your poor posture habits? ☐Yes ☐No If yes, explain: ____________

Are you aware of any poor posture habits in your spouse or children? ☐Yes ☐No If yes, explain: ____________

ASSIGNMENT OF BENEFITS

I HERBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITSS AND CAUSES OF ACTION TO THE ASSIGNEE. This is an assignment of my rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by Assignee for its services, and the company fails or refuses to make timely, complete payment, I authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to **Complete Wellness Medical Center, Inc.** ("Assignee"), Sums as may be due and owing Assignee for the services rendered to me both by reason of an accident or illness, and by reason of ant other bills that are due Assignee. I hereby authorize any insurance company to pay directly to Assignee the amount of this and/or future bills for services rendered to me and to release any information requested that is pertinent to my insurance company or attorney involved in this case.

Signature ____________ ***Date*** ____________

Print Name ____________ ***Date*** ____________

Activities of Daily Living

To what level are you experiencing symptoms while performing these activities?

Place an X in the corresponding box as it relates to your current symptoms.

(Example: 0= No effect: Able to perform the task without pain and/or limited function,
10= completely unable to perform activity due to pain and/or limited function.)

Wong-Baker FACES™ Pain Rating Scale

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

	0	1	2	3	4	5	6	7	8	9	10
Dressing											
Grooming											
Walking											
Sitting											
Standing											
Sitting to standing											
In/Out of bed											
Lifting											
Climbing Stairs											
Animal Care											
Cleaning											
Gardening											
Shopping											
Driving											
Exercise											
Sleeping											
Childcare											

These questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYMPTOMS

Please circle **ALL** that applies to you, if it does not apply to you please circle **"DENY"**

Constitutional: (DENY ALL) (chills) (night sweats) (weight gain) (daytime somnolence "drowsiness") (fatigue) (fever)

Eye vision: (DENY ALL) (blindness) (eye pain) (photophobia) (tearing) (blurred vision) (field cuts) (cataracts) (glaucoma) (change in vision) (itching around eyes) (wear glasses) (wear contacts)

Respiration: (DENY ALL) (asthma) (coughing up blood) (sputum production) (cough) (shortness of breath) (wheezing)

Cardiovascular: (DENY ALL) (angina) (chest pain) (claudication) (heart murmur) (heart problems) (orthopnea) (palpitation) (paroxysmal) (nocturnal dyspnea) (ulcers) (varicose veins)

Gastrointestinal: (DENY ALL) (abdominal pain) (belching) (black tarry stool) (constipation) (diarrhea) (difficulty swallowing) (heartburn) (hemorrhoids) (indigestion) (jaundice) (nausea) (rectal bleeding) (abnormal stool) (caliber) (abnormal stool color) (abnormal) (stool consistency) (vomiting blood)

Female: (DENY ALL) (birth control therapy) (breast lump/pain) (burning irritation) (frequent urination) (hormone therapy) (irregular menstruation) (urine retention) (vaginal bleeding) (vagina discharge)

Male: (DENY ALL) (burning urination) (prostate problems) (erectile dysfunction) (frequent urination) (urine retention) (hesitancy/dribbling)

Endocrine: (DENY ALL) (cold intolerance) (diabetes) (excessive thirst) (excessive hunger) (goiter) (hair loss) (heat intolerance) (unusual hair growth) (voice changes)

Skin: (DENY ALL) (changes in nail texture) (changes in skin color) (hair growth) (hair loss) (hives) (itching) (paresthesia) (rash) (history of skin disorders) (skin/ulcers) (varicosities)

Nervous System: (DENY ALL) (dizziness) (facial weakness) (headache) (limb weakness) (loss of consciousness) (loss of memory) (numbness) (seizure) (sleep disturbance) (stress) (stroke) (tremors)
(Unsteadiness of gait)

Psychologic: (DENY ALL) (anhedonia) (anxiety) (appetite) (changes of behavioral) (bipolar disorder) (confusion) (convulsions) (depression) (insomnia) (memory loss) (mood changes)

Allergy: (DENY ALL) (Anaphylaxis) (food intolerance) (itching) (nasal congestion) (sneezing)

Please list any health conditions you have had that are not mentioned:

____

____

Please list any medications you are currently taking and their purpose:

____

Please list all past surgeries:

____

____

PAYMENT POLICY

Payment is expected at the time of service unless payment arrangements have been made between you and the office manager prior to treatment.

• Health/Automobile Insurance:

- Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover.
- Ultimately, all services rendered to you are charged directly to you and you are responsible for payment. We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement. If your policy has a deductible feature, it is due at the time of service.
- We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above payment policy.

_______________________________________ _______________________

Patient Signature (or Parent/Guardian) **Date**

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

- I hereby authorize Complete Wellness Medical Center, Inc (CWCC), through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
- I further authorize Complete Wellness Medical Center, Inc (CWCC) to release to appropriate agencies, any information acquired in the course of my or the above mentioned patient's examination and treatment.

_______________________________________ _______________________

Patient Signature (or Parent/Guardian) **Date**

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge **I am NOT pregnant** and Complete Wellness Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period ________________________ **Initials**______________

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality patient care. "No shows" and late cancellations inconvenience other patients who need to access chiropractic care in a timely manner. Please be courteous and call CWCC at (386)734-2592, if you are unable to show up for an appointment. Please leave a message if you do not reach a receptionist. We will return your call and give you the next available appointment time. We require that you call 24 hours prior to your scheduled appointment to either cancel or reschedule. A "No Show" is someone who misses an appointment without cancelling at least 24 hours prior to your appointment.

A late cancellation or a "no show" will be subject to a $25.00 fee and grounds for discharge from our practice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no show".

_______________________________________ _______________________

Patient Signature (or Parent/Guardian) **Date**

Medical Record

We recognize that patient access to medical records is important and necessary to assure continuity of patient care. Upon written request, we will transfer your records to another physician or provide you with your medical record. The fees are below:

a) For the first 25 pages, the cost shall be $1.00 per page.
b) For each page in excess of 25 pages, the cost shall be $0.25 per page.

Patient's Signature______________________________________ **Date**________________

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting CWCC.

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, provide assistance with your diagnosis or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whoever answers or on your answering machine.
- We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy rights have been violated. Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

Patient's Signature______________________________________ Date __________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I was provided a copy of the Notices of Privacy Practices and that I read them or declined the opportunity to read them and understand the Notices of Privacy Practices. I understand that this form will be placed in my chart and maintained for six years.

Patient's Signature________________________________

Name Printed ________________________________ **relationship to patient**____________________

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS
I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURING
The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED
• *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
• *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
• *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in significant number of cases.
• *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED
Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

PATIENT SIGNATURE (or Parent/Guardian) _______________ **DATE** _______________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:____________________ Date of Birth:____________________

Phone: H)____________________ Phone: W) ____________________

Address:____________________ City/State/Zip: ____________________

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ____________________ Facility Phone: ____________________

Facility Address:____________________ Facility Fax:____________________

City, ST, Zip: ____________________

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: ____________________
- ☐ Specific Information Requested:

____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other____________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ____________________

Address: ____________________

City, State, Zip: ____________________ ☐ **Please mail records.**

Fax:____________________ Phone:____________________ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X____________________ ____________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.) Date

____________________ ____________________

Printed name of Authorized Representative Relationship / Capacity to patient

____

Address and telephone number of authorized representative