

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Cell (____) _____ Home (____) _____

Best time / # to reach you _____

Date of Birth _____ Age _____ Sex M F

Social Security Number _____

In Case of Emergency, contact:

Name _____ Relation _____

Phone _____

Married Single Other

Employed Student Other

Occupation _____

Employer _____

Spouse's name _____

How did you hear about us?

Referral (name) _____

Newspaper Internet Street Sign Event

ACCIDENT INFORMATION

Is this condition due to an accident? Yes No

Date of accident _____

Type of accident Auto Work Other

To whom have you reported your accident?

Auto Ins Employer Workers Comp

Accident info _____

INSURANCE INFORMATION

Insured's name _____

Relationship to patient _____

Insurance Co. _____

Insurance ID # _____

Group / Claim # _____

Secondary insurance? Yes No

Insurance Co. _____

Subscriber name _____

Birth date _____ SS# _____

Relationship to patient _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Rep

Print Name

Date

Relation to Patient

PATIENT CONDITION

Primary Complaint

Reason for today's visit? _____

When did your symptoms appear? _____ Is this condition getting: Worse Better Unchanged

Does the pain travel into your: R L Shoulder -arm- hand R L Buttox -leg- foot _____ Does not radiate

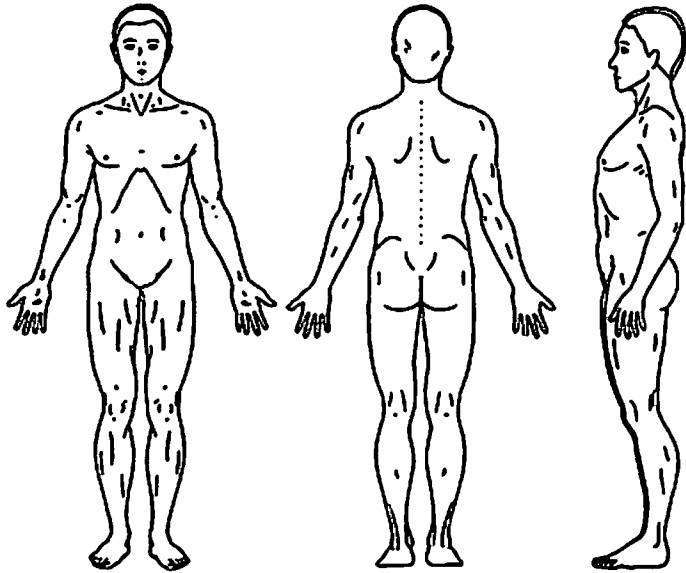
Have you had this before? What was done to treat it before? _____

What activities/positions make the symptoms worse? _____

What activities lessen your symptoms? _____

What percent of the day is this condition present? _____ Is it worse during a certain time of the day? _____

Is this condition interfering with: (please circle) Work Sleep Normal Routine Other _____



Using the symbols below, mark on the pictures where you feel the symptoms

- N = Numbness
- A = Dull Ache
- B = Burning
- S = Sharp/Stabbing
- P = Pins, Needles
- O = Other _____

PAIN INTENSITY

Please circle the number that describes your pain

0	1	2	3	4	5	6	7	8	9	10
None			Little			Medium				Severe

Secondary Complaint

Describe symptoms _____

When did your symptoms appear? _____ Is this condition getting: Worse Better Unchanged

Does the pain travel into your: R L Shoulder -arm- hand R L Buttox -leg- foot _____ Does not radiate

Have you had this before? What was done to treat it before? _____

What activities/positions make the symptoms worse? _____

What activities lessen your symptoms? _____

What percent of the day is this condition present? _____ Is it worse during a certain time of the day? _____

Is this condition interfering with: (please circle) Work Sleep Normal Routine Other _____

PAIN INTENSITY

Please circle the number that describes your pain

0	1	2	3	4	5	6	7	8	9	10
None			Little			Medium				Severe

*If you have additional complaints to discuss with the doctor, please let the front desk know and we will provide another form *

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic care None Others _____

Name of the doctor(s) who treated you for your condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ MRI / CT _____
 Spinal Exam _____ Chest X-Ray _____ Bone Scan _____

Please let us know if you have any of the following.

If you have the condition now, Place a "N" in the space; If in the past, Place a "P" in the space.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem | Others _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | _____ |

Recent Injuries / Falls / Broken bones / Dislocations / Surgeries _____

Medications (name and reason for taking) _____

Vitamins _____

EXERCISE	WORK ACTIVITY	HEALTH HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/ Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Caffeine Drinks	Cups/ Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Sleep	Hours/Night _____
	Hours/ Day _____	<input type="checkbox"/> High Stress	Reason _____

For Females: Are you pregnant? Yes No Do you take birth control pills? Yes No

PERSONAL GOALS

What activities of daily living or leisure activities are limited due to this condition? _____

On a scale of 0-10 (0 being the least and 10 being the most)

_____ How committed are you at being at your optimum health potential?

_____ How important is it for your family to be at their optimum health potential?

How do you want us to handle your problem? (please "X")

_____ Temporary Relief (Help the symptoms but do not fix the problem)

_____ Maxium Correction (Correct the cause of the problem for maximum stability in the future)

If you have previously seen a chiropractor, please describe any likes or dislikes (if any) so we may better serve you. _____

Ashville Chiropractic & Wellness Center

Terms of Acceptance

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

Chiropractic has only one goal. It is important that each patient understands both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine and other joint of the body.

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

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

We do not offer diagnosis or treat any disease. We only offer diagnosis of either vertebral subluxations or neuromusculoskeletal conditions. However, during the course of a chiropractic 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 service of another health care provider. Our only practice objective is to eliminate major interferences in the nervous system. Our only method is specific adjustments to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

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

Therefore, I accept chiropractic care on this basis.

Signature _____ Date ____/____/____

Consent to evaluate and adjust a minor child

I, _____ being the parent of _____
Have ready fully and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature _____ Date ____/____/____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors have my permission to perform any necessary x-ray evaluations. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle _____.

Signature _____ Date ____/____/____

Ashville Chiropractic & Wellness Center HIPAA Practice Requirements

The Practice:

- A) Is required by federal law to maintain the privacy of your PHI and to provide you with this privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- B) Under the Privacy Rule, may be required by state to grant greater access or maintain greater restrictions on the use or release of you PHI than that which is provided for under federal law.
- C) Is required to abide by the terms of this Privacy Notice.
- D) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- E) Will distribute and revised Privacy Notice to you prior to implementation.
- F) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 4/15/03

STATE LAW

A copy of the State HIPAA laws will be available to me at any time for my review, and a copy will be given to me upon my request.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature _____ Date ____/____/____