APPLICATION FOR CARE AT WELLSVILLE CHIROPRACTIC, LLC.

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-_____ Age: _____ ☐ Male ☐ Female
Name you wish to be called in our office: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Mobile Phone: _____
Other Phone: _____ Name of Spouse: _____
Employer: _____ Occupation: _____
Name & Number of Emergency Contact: _____ Relationship: _____
Who Can We Thank For Referring You To Our Office?: _____

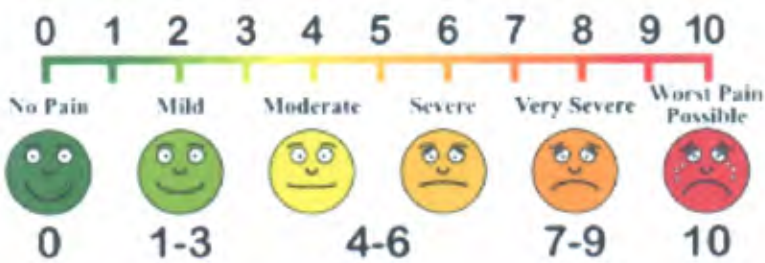
HISTORY of COMPLAINT(s)

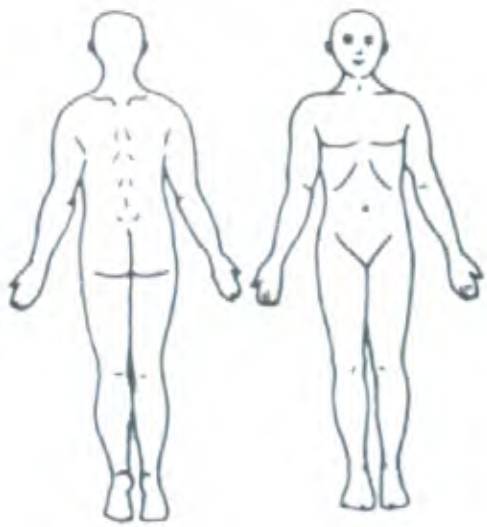
REASON FOR TODAY'S VISIT (explain):

When did problem begin? _____
What relieves your symptom? Rest Ice Heat Movement Stretching Other _____
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other _____
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** _____
How long does this problem last? _____ **# of prior episodes?** _____
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore

PLEASE MARK the Diagram with an "X" where you are having pain and discomfort

PLEASE CIRCLE BELOW: On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today





List any **current medications** and/or **supplements** you are taking (or provide list) _____
_____

Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes
If yes,
How long ago? _____ Please explain what type of accident: _____

PAST HISTORY & REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ None in this Category

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ None in this Category

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ None in this Category

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ None in this Category

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ None in this Category

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ None in this Category

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ None in this Category

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ None in this Category

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ None in this Category

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ None in this Category

Endocrine, Hematologic, Lymphatic
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ None in this Category

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ None in this Category

Women Only:
Are you pregnant?
- ☐ Yes - Due Date ___/___/____
- ☐ No – LMP ____/____/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ None in this Category

Pregnancies with Outcome & Date
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

SOCIAL HISTORY

1. Smoking: ❑cigars/pipe ❑ cigarettes ❑ e-cig/vape → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. How many years of school have you completed? ❑ High School ❑ College ❑ Post Grad ❑ Other

PERSONAL HISTORY:

1. Surgeries – Date, Type, and Reason (NONE) _____

_____

_____

2. Major Injuries, Trauma, Falls, Accidents/ Car Accidents, or Hospitalizations _____

_____

_____

3.Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes, explain

_____

_____

OFFICE FINANCIAL POLICY:

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up to date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all the benefit for which you are eligible; but financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits to which you are eligible. We will advise you to pay any amount due for the "deductible" or any other "non-covered" charges. Chiropractic maintenance care is treatment received in order to prevent future pain or health problems, prevent a relapse, and to improve the quality of life. Maintenance care is elective and is therefore not a covered service under most Insurance guidelines.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare. Chiropractic maintenance care is treatment received in order to prevent future pain or health problems, prevent a relapse, and to improve the quality of life. Maintenance care is elective and is therefore not a covered service under Medicare guidelines.

Personal Payment

Patients who do not have Chiropractic included in their insurance coverage are expected to make payments at each visit. For your convenience, we accept personal checks, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

How do you plan to take care of your charges today? ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance ❑ Other

_____ _____

Patient/Guardian Signature Date

PATIENT PRIVACY AND RELEASE OF HEALTH INFORMATION:

I hereby authorize the doctor and or clinic to disclose all or any part of my records to any person or cooperation which is or may be liable under a contract to the clinic, to the patient, to a family member, or employer of the patient for all or part of the clinics charges, including, and not limited to, hospital, medical service companies, insurance companies, workers compensation carriers, welfare funds, or the employer.

I authorize Wellsville Chiropractic to send me birthday, referral, and/or Christmas cards in the mail. √ YES ❑ NO

I authorize Wellsville Chiropractic permission to leave a message if I am unable to speak with them. √ YES ❑ NO

If you do not agree with these statements that are check marked please select NO.

Who has consent to pick up or discuss information on your care or finances in our office? (Family members, legal guardians etc) if their name is not listed below they will not be able to obtain any information from our office regarding your care or finances. You can update this list at any time but you will need to make the changes on this form only and you will need to date and initial any changes prior to obtaining the information.

_____

_____

_____

_____

I acknowledge that I have reviewed a copy of **Wellsville Chiropractic's HIPPA Policy** and have the right to request a copy at any time. Patient Name:_____ Patient Signature: _____ Date: _____

WELLSVILLE CHIROPRACTIC LLC INFORMED CONSENT & CONSENT TO TREAT:

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for
which I seek chiropractic care from this office.

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatments, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinical services that he/she deems necessary in my case.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature:_____ Date: _____