# C . A . R . E . HEALTH & WELLNESS CENTER

(Please Print)

| | | | | | |
|---|---|---|---|---|---|
| Today's date: | | | Primary Care Physician: | | |

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's last name: First: Middle: | | | ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Are you currently taking any medication or supplements? ☐ Yes ☐ No | If yes, please list? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F |
| Street address: | | Social Security no.: | | Home phone no.: ( ) | |
| P.O. box: | City: | | State: | ZIP Code: | |
| Occupation: | Employer: | | Email Address: | | |

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

## HEALTH INFORMATION

(Please give your insurance card to the receptionist.)

| | |
|---|---|
| What is your major complaint And how did it begin? | |
| How long have you had this condition? | |

Have you had this or similar conditions in the past? ☐ Yes ☐ No

Is this condition getting progressively worse? ☐ Yes ☐ No

Is this condition interfering with you: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Comes and Go

How much pain are you in from a scale of (0-10) Circle one **0 1 2 3 4 5 6 7 8 9 10**

Have you seen any other doctors for this condition? ☐ Yes ☐ No If Yes, please list doctors name and treatment >>>>

Have you ever had chiropractic care? ☐ Yes ☐ No If Yes, please list doctors name and treatment >>>>

List surgical operations and years:

Age of mattress? Do you wear: ☐ Heel Lifts ☐ Orthotics ☐ Inner Soles ☐ Arch Supports

Have you ever been into a car accident? ☐ Yes ☐ No

If yes, How long ago?

Briefly Describe: _____

_____

Interested in:

☐ Chiropractic ☐ Acupuncture ☐ Nutritional Supplements

☐ Rehabilitation ☐ Personal Training ☐ Weight Loss Program

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

| | | | |
|---|---|---|---|
| Please indicate primary insurance: | Policy Number: | Home phone no.: ( ) | Work phone no.: ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize C.A.R.E Health and Wellness Center or insurance company to release any information required to process my claims

*Patient/Guardian signature* *Date*

# C . A . R . E . HEALTH & WELLNESS CENTER

(Please Print)

Today's date:

## HEALTH QUESTIONNAIRE:

Patient's last name: First: Middle:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Please indicate for each of the questions below your experience by the use of the following codes:
[1] Never had [2] Previously had [3] Presently have

### MUSCULO-SKELETAL SYSTEM

- ☐ Low back problems
- ☐ Pain between shoulders
- ☐ Neck problems
- ☐ Chest or Rib problems
- ☐ Shoulder or Arm pain
- ☐ Hip pain
- ☐ Elbow or Wrist pain
- ☐ Stiff or painful joints
- ☐ Sore or weak muscles
- ☐ Walking problems
- ☐ Broken bones

### NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression

### RED FLAGS

- ☐ Loss of bladder function
- ☐ Loss of bowel function
- ☐ Blood in urine
- ☐ Unexplained Weight loss
- ☐ Awakening Pain
- ☐ Double/Blurred vision
- ☐ Ringing in ears
- ☐ Fever

### FEMALE

- ☐ Vaginal bleeding
- ☐ Last period
- ☐ Are you pregnant

### PRIOR HISTORY

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Allergies
- ☐ Arthritis
- ☐ Low back pain
- ☐ Neck pain
- ☐ Headaches
- ☐ Cancer
- ☐ Prior surgeries

_____

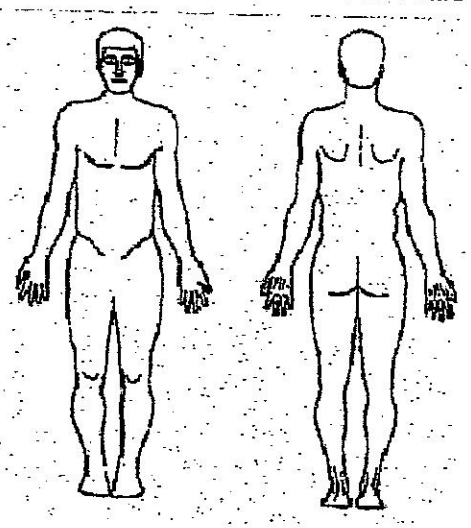
☐ Other

_____

### FAMILY/SOCIAL HISTORY:

- ☐ Heart disease
- ☐ Stroke
- ☐ Circulatory disorder
- ☐ Blood pressure
- ☐ Diabetes
- ☐ Other _____
- ☐ Employment _____
- ☐ Marital Status _____
- ☐ Smoking: ☐ Yes ☐ No
- ☐ Alcohol: ☐ Yes ☐ No

### MARK "X" WHERE YOU HAVE SYMPTOMS



# C.A.R.E. Health & Wellness Center

Erik Heyliger, DC, DAAMLP, CSCS
Chiropractic Physician/Strength & Conditioning Specialist
CT Lic # 1807/ Tax ID # 27-2431950

810 BEDFORD ST. Ste # 1
STAMFORD, CT 06901
(203) 295-3484
FAX (203) 295-3484

## RECORD RELEASE AUTHORIZATION

NAME _____

ADDRESS _____

PHONE O _____ H _____

SS# _____-____-_____ D.O.B._____/_____/_____

I HEREBY authorize the attending doctor to release any information concerning my examination or treatment.

PATIENT SIGNATURE _____

Attorney Name/ Address

Insurance Company Name/Address

__Male
__Female

Patient's Relationship to Insured
__Self __Spouse __Child Other

Was condition related to:
Patient's employment __Yes __No
Auto accident __Yes __No
Policy Holder or Employer _____
Insured _____ SS# _____
POLICY NO._____ CLAIM NO._____
Has patient ever had same or similar symptoms? __Yes __No Dates of Disability __Total __Partial
From_____ Through_____
Return to work date_____
DIAGNOSIS: (ICD-9CM) NEW DIAGNOSIS ____ UPDATE ____
1._____ 3._____
2._____ 4._____

C.A.R.E. Health & Wellness Center

Erik G. Heyliger, DC, DAAMLP, CSCS
Chiropractic Physician/Strength & Conditioning Specialist
www.carehealthandwellness.com

810 Bedford St. Ste #2
Stamford, CT 06901
T(203) 295-3484/F (203) 295-3484

# 24 Hour Appointment Cancellation Policy

The C.A.R.E. Health & Wellness Center has a 24 hour cancellation / rescheduling policy.

**If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $ 75.**

This policy is in place out of respect for our doctors, therapists, and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for C.A.R.E. Health & Wellness Center described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date

C.A.R.E.
HEALTH & WELLNESS CENTER
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I HEARBY ASSIGN PAYMENT directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor.

PATIENT SIGNATURE _____

**We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like the information in a different form please advise us in writing as to your preferences.**

**You have the right to inspect and or copy your health information for seven years from the date this record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.**

**We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.**

**We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all your health information in our files.**

**Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.**

**If you have a complaint regarding our privacy notices, our privacy practices, or any aspect of our privacy activities you should direct to your complaint Dr. Erik Heyliger immediately.**

**If you would like further information about our privacy policies and practices please contact Dr. Erik Heyliger.**

**This notice is effective as of 1, 2009. This notice, and any alterations or amendments made here will expire seven years after the date upon with the record was created. My signature acknowledges that I have received a copy of this notice.**

| Name (printed please) | Signature | Date |
|---|---|---|

**If you are a minor, or if you are being represented by another party**

| Personal Representative (print) | Personal Representative (signature) | Date |
|---|---|---|

**Description of authority to act on behalf of the patient:**