Chiropractic & Wellness Center, PC

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
DOB _____ SS#_____ Marital Status: S M D W Sex: M/F Age_____
Occupation_____ Employer_____
Work Address_____
Parents/Legal Guardians Name (if under18) _____ Parents phone _____
No. of Children _____ How did you hear about our office?_____
Email Address:_____ ☐ Check box if you do not want to receive our health newsletter

Main Complaint

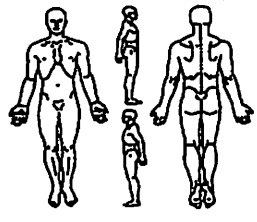
1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
   _____
3. What is your treatment goal? _____
4. If this is a recurrence, when was the first time you noticed the problem? _____
5. How did it originally occur? _____
6. Has it become worse recently? Yes_____ No_____ Same_____ Gradually Worse_____
   If yes, when and how? _____
7. How frequent is this condition? Constant_____ Daily _____ Intermittent_____ Night Only_____
8. How long does it last? All Day___ Few Hours___ Minutes___
9. How many days have you lost from work due to these symptoms:? _____
10. Are there any other conditions or symptoms that may be related to your major symptoms
    Yes___ No___. If yes, describe _____
11. Are there other related health problems? Yes____ No____ If yes, describe _____
    Describe the pain: Sharp_____ Dull_____ Numbness_____ Tingling_____ Aching_____ Burning_____
    Stabbing_____ Other _____
12. Is there anything you can do to relieve the problem? Yes___ No___
    If yes, Describe_____
    If no, what have you tried to do that has not helped? _____
    _____
13. What makes the problem worse? Standing___ Sitting___ Lying___ Bending___ Lifting___ Twisting___
    Other_____
14. Have you had any broken bones? Yes___ No___. If yes, please list and give dates_____
    _____
15. List any major accidents you have had other than those that might be mentioned above_____
    _____
16. To you knowledge, have you had any disease, major illnesses, or injuries not indicated on this form either in past or the present? _____
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes___ No___ Uncertain___
    Remarks:_____
    _____
    _____

NO PAIN Unbearable Pain

[_____]

Please place an "X" on the line above to indicate level of problem

Show area(s) of pain, discomfort or unusual feeling



Medical History

Past Chiropractic care / doctor's name_____

Family physician_____ Medications/Vitamins_____

Surgeries / dates_____

Illness / abnormalities _____

Previous Injuries & accidents / dates_____

Do you have any difficulty with any of the following?

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus Trouble
- ☐ Loss of smell
- ☐ Hayfever
- ☐ Asthma/allergies
- ☐ Loss of taste
- ☐ Tightness in throat
- ☐ Inflammation of throat
- ☐ Thyroid Trouble
- ☐ Face flushed
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Head feels too heavy
- ☐ Weight gain
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Light bothers eye
- ☐ Muscle spasms in neck
- ☐ Grating in neck
- ☐ Tightness of shoulder muscles
- ☐ Neuritis in shoulders & arms
- ☐ Pins & needles in hand
- ☐ Cold hands
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Heart attacks
- ☐ Heart pain
- ☐ Heart palpitations
- ☐ Weight loss
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Nervous Stomach
- ☐ Stomach Trouble
- ☐ Ulcers
- ☐ Nerves & Nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Cold sweats
- ☐ Liver trouble
- ☐ Gall Bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Constipation
- ☐ Bladder trouble
- ☐ Menstrual cramps & pain
- ☐ Menstrual Irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Arthritis
- ☐ Slipped disc
- ☐ Pinched nerves in back
- ☐ Pins & needles in legs
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pains in legs & feet
- ☐ Kidney Trouble

Family Medical History

Allergies	Cancer	Diabetes	Osteoporosis	Mental Illness
Asthma	Arthritis	Stomach Disorders	Alzheimer's	Stroke
Heart Disease	Kidney Disease		Alcoholism	Obesity

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you marked in the section above

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are major causes? Work Family Finances Relationships Emotions

Other_____

I eat the following: Sweets Sodas/Pop Ice Cream Fried Foods
Cereals Legumes Fruits Vegetables

List your 4 favorite foods:_____

This applies to me: Diet frequently Skip meals Dine out regularly

Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning Noon Night Constantly snacking

Do you:

-Use tobacco? YES or NO If yes, how much daily? _____

If no, did you ever? YES or NO if yes how much?_____

-Have exposure to second hand smoke? YES or NO If yes, how much daily?_____

If no, did you ever? YES or NO if yes how much?_____

-Drink Coffee? YES or NO If yes, how much daily? _____

If no, did you ever? YES or NO if yes how much?_____

-Eat Chocolate? YES or NO If yes, how much daily?_____

-Drink Alcohol? YES or NO If yes, how many ounces a day/week? _____

If no, did you ever? YES or NO if yes how much?_____

How long did you drink before you stopped?_____

-Restrict your intake or avoid completely:

Fiber Salt Sugar Fat
Dairy products Animals protein All animal foods Other

Exercise

Exercise weekly? YES or NO If yes, how many times per week?_____

I agree that the information I provided is correct_____

CHIROPRACTIC & WELLNESS CENTER (CWC)
CONSENT FORM

For Use and Disclosure of Protected Health Information (PHI)

In signing this form, you consent to the use and disclosure of your protected health information by Chiropractic & Wellness Center, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You have the right to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices.*** It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, by contacting our facility at (317) 580-9867.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please ask for a separate form. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grand my consent for Chiropractic & Wellness Center to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient or
Surrogate Decision Maker: _____ **Date:** _____

Relationship to Patient/ Legal
Authority (if applicable): _____

For CWC Use Only:
Failure to obtain consent check the appropriate reason:

_____ Indirect treatment relationship exists _____Emergency treatment

_____Substantial barriers in communication _____Refusal to sign

_____Other

Description:

_____

_____

CWC Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Financial Policy

Insurance Coverage

Welcome to Chiropractic and Wellness Center. Your insurance is an agreement between you and your insurer, not between your insurer and this office. Coverage for chiropractic and therapy services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay a co-insurance, co-payment, and /or deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 deductible. Our office will call your insurer to verify your benefits, however, this is NOT a guarantee of payment from your insurer.

Payments

In order to help you determine your responsibility toward your payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (*please initial*)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B _____I have insurance, but your office is OUT OF NETWORK, and I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (*please initial*)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the cost of treatment(s).

D_____ I would like to opt out from billing my health insurance for office visits at your clinic. I want to pay the time-of-service rate, and will keep my balance current. I also understand this option does NOT allow me to file the office visits with my insurance company.

Missed Appointments

It is the policy of Chiropractic & Wellness Center to assess a $10 missed visit fee for chiropractic, $25 missed visit fee for physical therapy, and one half the fee of all massage appointments, to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This office provides care for many individuals and missed office visits result in time lost that could have been used to provide care for others. Please be courteous when scheduling or rescheduling.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions in this policy. I fully consent to receiving treatment from any or all practitioners in this practice.

_____ _____

Signature **Date**

Chiropractic & Wellness Center

Chiropractic & Wellness Center
1305 W. 96th street
Indianapolis, IN 46260
317-580-9867

Chiropractic & Wellness Center
5649 N 800 W. (Carroll Road)
McCordsville, IN 46055
317-826-9751

Primary Insurance Information

Name of Primary Insured: _____

Primary SS# _____ **Primary DOB**_____

Insurance Name:_____ **Insurance Phone #**_____

ID Number _____ **Group Number**_____

Relationship to Insured: _____

Patient Signature:_____ **Date:**_____

(or signature of legal guardian if patient is under the age of 18)