Date: _____

PATIENT APPLICATION SURVEY / BWC

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone:_____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Family Physician and/or Referring Physician's Name and Number: _____

RESPONSIBLE PARTY INFORMATION

BWC Claim Number _____ MCO Name _____ Phone # _____ ext _____

Worker Comp Attorney's Name (if applicable) _____ Phone # _____

Date of your work accident/injury _____

Your Private Insurance Name _____ Phone # _____ ext _____

Policy Number _____ Group Number _____

Name of Policy Holder _____ Phone Number _____

WORK ACCIDENT INFORMATION

Have you ever been under chiropractic or physical therapy care before this injury? [ ] Yes [ ] No **If Yes**, by whom _____

Is this visit related to your work injury? [ ] Yes [ ] No **If so**, when was the date of the injury _____

Please describe the injury and/or accident in **detail**: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EXPERIENCE WITH CHIROPRACTIC or PHYSICAL THERAPY

Have you seen a Chiropractor or Physical Therapist before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond to care? _____

Did your previous Doctor of chiropractic take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? [ ] YES [ ] NO

HEALTH LIFESTYLE

Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? [] Running [] Jogging [] Weight Training [] Cycling [] Yoga [] Pilates [] Swimming [] Other _____

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much / week? _____

Do you drink coffee? [ ] Yes [ ] No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Please list any medications you are currently taking _____

_____

Please list any health conditions not mentioned: _____

Please list any significant family history: _____

_____

Have you ever tested HIV positive [] YES [] NO

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

PLEASE ONLY FILL OUT THIS PAGE IF YOU WERE INJURED IN A AUTOMOBILE WORK ACCIDENT

1. Were you the [ ] Driver [ ] The Passenger [ ] A Pedestrian [ ] On A Bicycle [ ] On A Motorcycle

2. Who was at fault [ ] You or [ ] The other driver? Were you [ ] hit by the other car or [ ] the other car hit you

3. From which side were you struck [ ] behind [ ] the front [ ] the right side [ ] the left side [ ] the right front [ ] the left front [ ] the right back [ ] the left back

4. At the time of impact you were [ ] stopped [ ] moving [ ] walking [ ] standing still [ ] running [ ] bicycling [ ] riding a motorcycle [ ] crossing the street

5. Were you moving at the time of the accident? [ ] Yes or [ ] No **If yes,** what was your speed? _____

6. Was the involved party moving when the accident occurred? [ ] Yes or [ ] No **If Yes**, what was their speed? _____

7. Did you have your seatbelt on at the time of the accident [ ] Yes [ ] No

8. Was your head turned at the time of the accident [ ] Yes or [ ] No **If Yes**, were you looking [ ] Forward [ ] Looking to the Right [ ] Looking to the Left [ ] Looking Behind You [ ] Looking Up into mirror [ ] Looking Down

9. Were you alone at the time of the accident? [ ] Yes [ ] No

10. What parts of your body hit other structures at the time of impact?

    [ ] Head [ ] Face [ ] Forehead [ ] Back of Head [ ] Right TMJ [ ] Left TMJ [ ] Right Shoulder [ ] Left Shoulder [ ] Right Arm [ ] Left Arm [ ] Right Elbow [ ] Left Elbow [ ] Right Wrist [ ] Left Wrist [ ] Right Hand [ ] Left Hand [ ] Right Leg [ ] Left Leg [ ] Right Knee [ ] Left Knee [ ] Right Ankle [ ] Left Ankle [ ] Right Foot [ ] Left Foot

11. What structures did you hit?

    [ ] Steering Wheel [ ] Windshield [ ] Side Window [ ] Door [ ] Roof [ ] Dashboard [ ] Headrest [ ] Seat [ ] Floor [ ] Side of Car [ ] Hood of Car [ ] Bumper [ ] Trunk [ ] The Pavement [ ] Tree [ ] Another Car [ ] Another Person [ ] Another Object [ ] A Wall

12. How did you feel after the collision? [ ] Stunned [ ] Disoriented [ ] Lost Consciousness [ ] Tightness [ ] Felt Mild Discomfort [ ] Felt Moderate Discomfort [ ] Felt Severe Discomfort [ ] Felt Intense Pain [ ] Frightened [ ] Felt a Popping and Ripping Sensation [ ] Went to the Hospital

13. Who was cited for the accident? [ ] Me [ ] The Other Driver

Please List Any Past Surgeries: _____

_____

_____

RADIOGRAPH CONSENT FORM

I _____ do hereby give my consent to allow Complete Wellness Chiropractic and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient or Guardian of a Minor/Child_____ Date _____

HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **COMPLETE WELLNESS CHIROPRACTIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Complete Wellness Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Complete Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor or Therapist in private, the Doctor or Therapist will provide a private room for these conversations.

By signing the following you are giving Complete Wellness Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

IN CASE OF EMERGENCY CALL:

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____