

Welcome To Paradise Chiropractic & Wellness Center

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age ____ Today's date ____/____/____
 Mailing Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Cellular # () _____
 _____ Male _____ Female Soc. Sec. # _____ - _____ - _____ E-mail Address _____ Employer _____
 # of Children _____ Ages of Children _____ Single Married Significant Other Widowed Separated Divorced
 Your occupation _____ Work duties _____ **WOMEN ONLY: Are you pregnant? No Yes** _____
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Who may we thank for referring you to our office? _____ Method of payment: FSA HSA Cash Check CC _____

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

____ Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both	____ Hip Pain R / L	____ Neck Stiffness/ Pain	____ Back Stiffness/Pain
____ Headaches/Migraines	____ Arthritis	____ Frequent Colds / Flu	____ Diabetes
____ Fractured Bones	____ Convulsions/Epilepsy	____ Skin Problems	____ Smoking
____ Swollen Painful Joints	____ Tremors	____ Blurred Vision R / L	____ Double Vision R / L
____ Anemia	____ Chest Pain	____ Lung Problems	____ Loss of Taste
____ Pain w/ Cough / Sneeze	____ Stroke	____ Gall Bladder Problems	____ Digestive Problems
____ Heart Problems	____ Kidney Trouble	____ Loss of Smell	____ Loss of Balance
____ Prostate Problems	____ Buzzing/Ringing in ears	____ Sinus Problems/Allergies	____ Nervousness/Anxiety
____ Dizziness/Vertigo	____ Depression	____ Irritability/Mood Swings	____ Tension/Stress
____ Fatigue	____ Sleeping Problems	____ Cold Hands	____ Stomach Upset
____ Colon Trouble	____ Bed Wetting	____ Recurring Infection	____ Diarrhea/Constip./Gas
____ Cold feet	____ Shortness of Breath	____ Hot Flashes	____ Jaw/TMJ Problems
____ Foot Problems	____ Cancer (Type) _____	____ Problems Urinating	____ Heartburn/Reflux
____ Cold Sweats	____ PMS	____ Menopause	____ Ulcers
____ High Blood pressure			

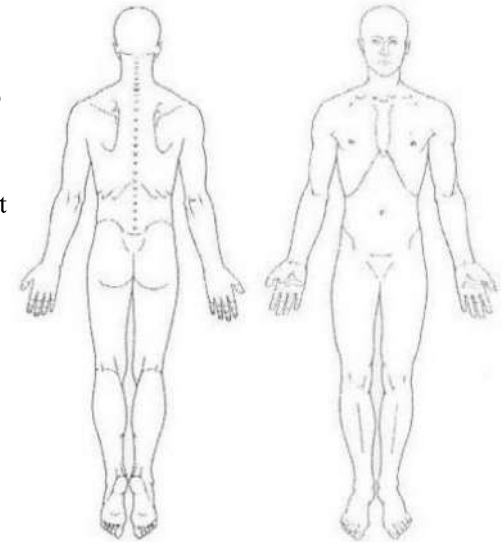
Medications: What Medications are you currently taking and for what Conditions? _____

Have you ever been to a chiropractor before? Y / N If NO why not? _____

Current Health Condition

Chief Complaint/Location of Subluxation (why you are here today): _____

Please mark on the diagram below the area of discomfort. ↓



When did this condition/subluxation begin? _____ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain. (ex. fall, auto, sports,) _____

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels? _____

Does this pain travel or radiate? If so, Where? _____

Quality: (circle all that apply)

Burning Diffuse Dull/Aching Localized Radiating
 Sharp Shooting Stabbing Tingling Other _____

Is there anything that makes this better? _____

Is there anything that makes this worse? _____

Rate the severity of your symptoms or condition (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Is the condition/subluxation getting better, worse, or staying the same? _____

Worse AM Worse PM Worse W/ Activity Worse Sleeping

Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

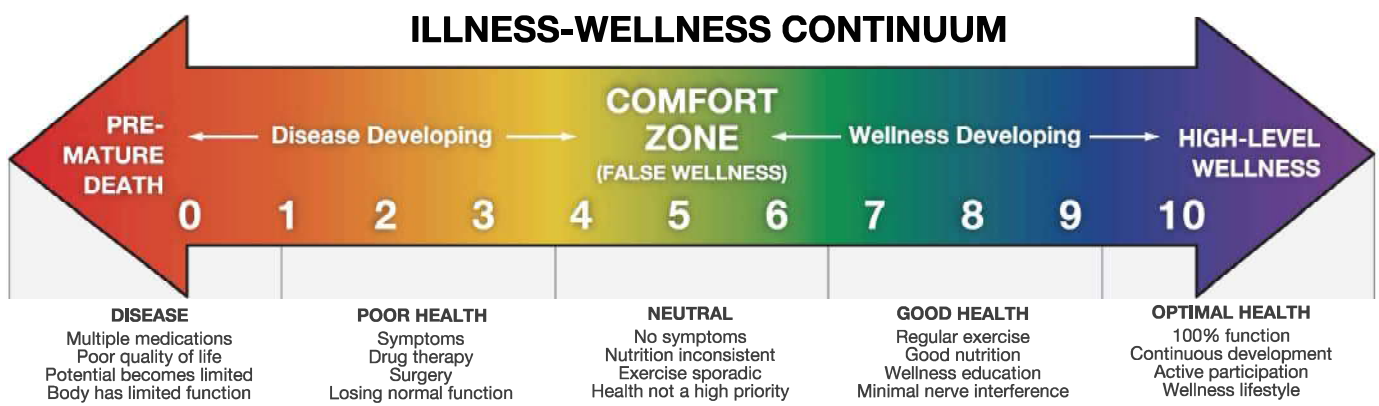
Have you suffered with this or a similar problem in the past? No Yes If yes how many times? _____ When was the last episode? _____

When was the first? _____ How did the injury happen? _____

What solutions have you attempted to solve this problem? _____ Were the results: Favorable Unfavorable

Please Mark the Diagram Accordingly Above:
 R=Radiating B=Burning D=Dull A=Aching S=Sharp
 N=Numbness T=Tingling

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Changing Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please List any effects that this may have on any Recreational Activities: _____

Please circle all Major and Minor Traumas that you have experienced: These all can cause your Condition

Sports/Exercise Poor Posture Bad Habits Lifestyle Stress Extended Sitting Extended Standing Work Injuries
 "Adjusting or Popping" your own Spine Extended Cell Phone or Computer use: Hours used a day____
 Car Accidents: Number of Accidents____ Slips/Falls: Adult____ Child____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

____ Temporary Relief (Symptomatic) ____ Maximum Correction (Correct the problem & reduce chance of reoccurrence)

How committed are you to correcting the problem?(1-10) ____ Any factors that would limit you from correction? _____

The questions below will allow us to better serve you.

What is most important to you when it comes to your relationship with your health care provider and your overall office experience? _____

Would you say you are open and interested in new and cutting edge health care practices or more comfortable with conventional approaches? _____



HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Difficulty Sleeping							
Disc Problems							
Ear Problems							
Emphysema							
Epilepsy/Seizures							
Fatigue							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neck Pain							
Numbness							
Pinched Nerve							
Scoliosis							
Sinus & Allergies							
Stomach Trouble							


Paradise Chiropractic & Wellness Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Paradise Chiropractic & Wellness Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized person's Signature Date


REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on _____ - _____ - _____ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.


By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized person's Signature Date

Minor Consent (Under 18):

The undersigned parent/guardian of _____ (patient name) _____ (DOB of Patient) hereby empowers and grants : **Paradise Chiropractic & Wellness Center** consent to authorize medical care for any and all treatments for my above child/ward. This authorization shall be valid through the duration of care, unless otherwise advised in writing by the parent or legal guardian that consent should be terminated. This consent allows for all treatments.

I do hereby indemnify and hold harmless the physicians, and other healthcare professionals who act in reliance upon this authorization.

_____ / ____ / ____  *Witness Initials*
Parent/Guardian's Signature Date

Paradise Chiropractic and Wellness Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our office. If we are unavailable, you may make an appointment with our receptionist to see us within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

Paradise Chiropractic and Wellness Center *NOTICE REGARDING YOUR RIGHT TO PRIVACY*
continued....

I have read/received a copy of Paradise Chiropractic and Wellness Center Patient's Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

DOB

HR#

Patient signature

Date

Witness

Date



Account Payment Notice & Authorization

Please complete all fields. You may cancel this authorization at any time by contacting our office and confirmation that your account balance is paid in full. This authorization will remain in effect until canceled.

Our Health Care System has gone through many changes. We are happy to **submit claims to your insurance company** for services rendered at our office and provide **Cash fees** or **Care plan Options** for any services provided to you. We want to continue providing you with excellent care, but in order to do so, it is necessary to ensure reimbursement for our products and services.

Please read the following and initial each box:

_____ I understand if I choose to pay by Cash or I utilize Insurance (not on an active care plan), I am required to pay at time of service or product purchase and my account must have a \$0 balance.

_____ I understand the amount charged to my card shall not exceed the amount my insurance deems as my responsibility and/or Cash/Careplan fee/Product.

_____ I understand that I am responsible for any services provided by Paradise Chiropractic & Wellness Center. This may include, but is not limited to, **Deductibles, Co-Insurances, Co-Pays, Cash Fees, Agreed Careplan Investments and Services not covered under my Insurance policy.**

_____ I understand if my Credit Card is declined I will be informed immediately and an alternate form of payment must be given or the alternate card on file will be used. I understand any form of payment/credit card used at the office maybe kept on file and could be used as an alternative form of payment.

_____ I understand I will be sent a text/email/phone call informing me of the amount to be charged to my credit card before charging my card. A receipt will be sent upon request.

Payment Method

- Cash/Check - Payment Due at the Time of Service Credit/Debit Card - Card is on File

I, _____, am aware of Paradise Chiropractic & Wellness Center's patient account policy. If I am utilizing insurance or using a credit card for payment, I authorize the office to process my account balance to my credit card for agreed purchases and services rendered. I understand that my information will be saved to my file for future transactions on my account.

Patient/Customer Signature

Date

Authorized Users