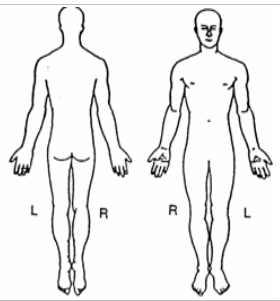
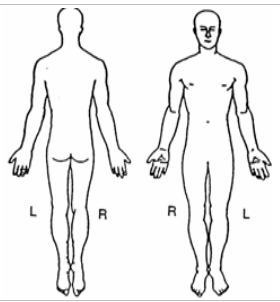
ABSOLUTE Wellness

CONFIDENTIAL PATIENT INFORMATION

Name _____ SSN _____ Date _____
Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Sex □ M □ F Birthdate _____ Age _____
Occupation _____ Employer _____
Work Address _____ Work Phone _____
Who may we thank for referring you?_____ Marital Status S M W D
Spouse's Name _____ Spouse's Employer _____
Have you had chiropractic care previously? □ No □ Yes When _____ Doctor's Name _____
Would you like to receive reminders? □ Text □ Email Cellular Carrier _____
Please list your most recent traumas with date of occurrence. (Auto Accidents, Falls, Sports Injuries, Etc.) _____
_____
_____

	PRIMARY CONCERN	SECONDARY CONCERN
Please describe concerns and symptoms that are causing you to seek treatment.	_____ _____	_____ _____
When did symptoms start?		
Have you had these symptoms previously?	□ Yes, when? _____ □ No	□ Yes, when? _____ □ No
The pain is...	□ Constant □ Comes and Goes □ Dull □ Burning □ Sharp/Stabbing □ Tingling □ Causing Restrictions □ Causing Weakness □ Traveling, where?_____	□ Constant □ Comes and Goes □ Dull □ Burning □ Sharp/Stabbing □ Tingling □ Causing Restrictions □ Causing Weakness □ Traveling, where?_____
What makes the pain better?	□ Chiropractic Care □ Ice □ Heat □ Massage □ Resting □ Sitting □ Standing □ Walking □ Lying Down □ Other _____	□ Chiropractic Care □ Ice □ Heat □ Massage □ Resting □ Sitting □ Standing □ Walking □ Lying Down □ Other _____
What makes the pain worse?	□ Bowel Movements □ Driving □ Breathing □ Coughing □ Lying Down □ Sitting □ Walking □ Standing □ Sneezing □ Working □ Other _____	□ Bowel Movements □ Driving □ Breathing □ Coughing □ Lying Down □ Sitting □ Walking □ Standing □ Sneezing □ Working □ Other _____
Have you missed any work/ school due to this complaint?	□ Yes □ No	□ Yes □ No
Is this issue the result of an automobile accident or work-related injury? Explain.	□ Automobile Accident □ Work-Related _____ _____	□ Automobile Accident □ Work-Related _____ _____
Have you received any other treatment for this issue? What type?	□ Chiropractic □ Physical Therapy □ Surgery □ Other_____ Physician's Name _____	□ Chiropractic □ Physical Therapy □ Surgery □ Other_____ Physician's Name _____
Please mark your areas of pain on the figure. Use the corresponding character to indicate the type of pain in each area. ++ Sharp/Stabbing ## Burning XX Tingling/Numb 00 Dull		
Please circle the activities that are affected by this issue.	Bathing Sleeping Brushing Teeth Caring for Family Carrying Items Washing Body/Hair Cooking Dressing Climbing Stairs Computer Use Lifting Items Changing Positions Driving Eating Concentration Daily Pet Care Work Activities Getting Out of Bed Sports Bending Sneezing Exercising Lying Down Household Chores Shaving Reaching Showering Sexual Activities Static Sitting Reading Running Swallowing Yard Work	
Doctor's Notes		

Medication Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Nutrients Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Females Only Are you currently having menstrual cycles? Y N

If yes, when was the first day of your last cycle? _____ Is there any chance you are pregnant? Y N

Family History Insert ages and check any box that applies.

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other												

Diet Indicate if the substance is used, type, how much, how often.

Substance	Used?	Type	How Much/How Often
Water	□ Yes □ No		_____Glasses Per Day
Caffeinated Beverages	□ Yes □ No		_____Per Day
Alcohol	□ Yes □ No		_____Per Week
Fast Food	□ Yes □ No		_____Per Week
Tobacco	□ Yes □ No		_____Per Day
Fruits/Vegetables	□ Yes □ No		____Servings Per Day

Body Composition/Exercise Please fill in the chart.

Current Weight	_____	
Ideal Weight	_____	
Interested in Weight Management?	□ Yes □ No	
		How Often
Cardio Exercises	□ Yes, type? _____ □ No	_____ Per Week
Resistance/Weight Training	□ Yes, type? _____ □ No	_____ Per Week
Pain After Exercise?	□ Yes, where? _____ □ No	
Play Sports?	□ Yes, type? _____ □ No	

Commitment/Goals

From 1-10, what is your daily stress level? _____

From 1-10, how committed are you to making lifestyle improvements? _____

What are your health goals for the next six months? _____

_____

_____

Primary Care Physician

Physician's Name _____ Physician's Phone Number _____

Address _____ City _____ State ____ Zip_____

□ Check here if you do NOT authorize this office to communicate with my primary physician about the care I receive.

Signature _____

Subjective Health Assessment Please rate the following symptoms that you have experienced during the past 30 days.

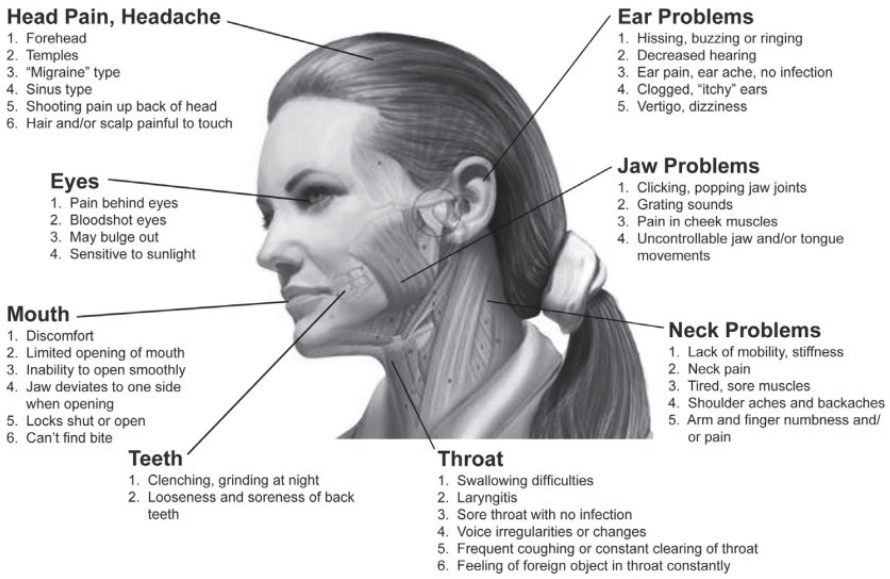
0= Never 1= Occasional and Mild 2= Occasional and Severe 3= Often and Mild 4= Often and Severe

	Head			**Heart, Lungs**	
0 1 2 3 4	Headache		0 1 2 3 4	Irregular Heart Beat	
0 1 2 3 4	Faintness		0 1 2 3 4	Rapid, Pounding Heart Beat	
0 1 2 3 4	Dizziness		0 1 2 3 4	Chest Pain	
0 1 2 3 4	Sleeplessness	___Total	0 1 2 3 4	Chest Congestion	
			0 1 2 3 4	Asthma	
	Eyes, Ears, Nose, Throat		0 1 2 3 4	Bronchitis	
0 1 2 3 4	Stuffy Nose		0 1 2 3 4	Shortness of Breath	___Total
0 1 2 3 4	Sinus Trouble				
0 1 2 3 4	Hay Fever			**Skin**	
0 1 2 3 4	Sneezing		0 1 2 3 4	Acne	
0 1 2 3 4	Nasal Congestion		0 1 2 3 4	Dry, Scaly Skin	
0 1 2 3 4	Swollen Eyes		0 1 2 3 4	Hair Loss	
0 1 2 3 4	Reddened Eyes		0 1 2 3 4	Excessive Sweating	
0 1 2 3 4	Watery, Itchy Eyes		0 1 2 3 4	Oily Skin	
0 1 2 3 4	Dark Circles Under Eyes		0 1 2 3 4	Hot Flashes	___Total
0 1 2 3 4	Blurred Vision				
0 1 2 3 4	Earache, Ear Infection			**Digestion**	
0 1 2 3 4	Ringing in the Ears		0 1 2 3 4	Nausea, Vomiting	
0 1 2 3 4	Coughing		0 1 2 3 4	Diarrhea	
0 1 2 3 4	Sore Throat		0 1 2 3 4	Constipation	
0 1 2 3 4	Hoarseness, Loss of Voice		0 1 2 3 4	Heartburn	
0 1 2 3 4	Canker Sore		0 1 2 3 4	Stomach Pain	
0 1 2 3 4	Discolored Lips or Gums	___Total	0 1 2 3 4	Bloating	
			0 1 2 3 4	Belching, Gas	___Total
	Memory, Emotions				
0 1 2 3 4	Mood Swings			**Joints**	
0 1 2 3 4	Anxiety, Nervousness		0 1 2 3 4	Stiffness/Lack of Motion	
0 1 2 3 4	Anger, Irritability		0 1 2 3 4	Arthritis	
0 1 2 3 4	Aggressiveness		0 1 2 3 4	Pain in the Muscles	
0 1 2 3 4	Depression		0 1 2 3 4	Pain in the Joints	___Total
0 1 2 3 4	Poor Memory				
0 1 2 3 4	Confusion			**Energy Levels**	
0 1 2 3 4	Lack of Concentration		0 1 2 3 4	Weakness	
0 1 2 3 4	Difficulty in Making Decisions		0 1 2 3 4	Fatigue	
0 1 2 3 4	Stuttering		0 1 2 3 4	Hyperactivity	
0 1 2 3 4	Slurred Speech		0 1 2 3 4	Restlessness	___Total
0 1 2 3 4	Learning Disabilities	___Total			
				Weight	
			0 1 2 3 4	Binge Eating/Drinking	
			0 1 2 3 4	Craving Certain Foods	
			0 1 2 3 4	Excessive Weight	
			0 1 2 3 4	Water Retention	
			0 1 2 3 4	Overweight	___Total
				Grand Total	_____

Signs and Symptoms of Oral/Facial Pain

Check Below:

- ☐ HEADACHES
- ☐ JAW JOINT PAIN
- ☐ JAW JOINT NOISE OR CLICKING
- ☐ LIMITED MOUTH OPENING
- ☐ EAR CONGESTION
- ☐ DIZZINESS
- ☐ RINGING IN EARS
- ☐ DIFFICULTY SWALLOWING
- ☐ LOOSE TEETH
- ☐ CLENCHING OR GRINDING
- ☐ FACIAL PAIN
- ☐ SENSITIVE TEETH
- ☐ CHEWING DIFFICULTIES
- ☐ NECK PAIN
- ☐ POSTURAL PROBLEMS
- ☐ TINGLING IN FINGERTIPS
- ☐ HOT & COLD TEETH SENSITIVITY
- ☐ NERVOUSNESS OR INSOMNIA



I verify that the information I have provided in this document is true and I give the doctor consent to treat me.

Printed Name _____

Signature _____

Date _____

Emergency Contact

Printed Name _____ Relationship _____ Phone _____

Printed Name _____ Relationship _____ Phone _____

MASSAGE CANCELLATION POLICY

Massage therapy at Absolute Wellness is used for both relaxation and treatment in conjunction with chiropractic care. Due to the limited number of available appointment, we must enforce a cancellation policy.

Patients must provide no less than **24-hours notice** for cancelling a massage therapy appointment. If sufficient notice is not received, a **$30 cancellation fee** will be charged at the patient's next office visit. This charge is the responsibility of the patient. Insurance will not be billed to cover this fee.

I, _____, understand that it is my responsibility to cancel massage appointments **24-hours** prior to my scheduled appointment. I understand that I will be charged and agree to pay a **$30 cancellation fee** should I fail to do so.

Signature _____ Date _____

REHAB CANCELLATION POLICY

Rehab appointments at Absolute Wellness are intended to be part of a treatment plan along with chiropractic care. Failure to attend a scheduled rehab appointment may lengthen your recovery.

Patients must provide no less than **24-hours notice** for cancelling a rehab appointment. If sufficient notice is not received, a **$30 cancellation fee** will be charged at the patient's next office visit. This charge is the responsibility of the patient. Insurance will not be billed to cover this fee.

I, _____, understand that it is my responsibility to cancel rehab appointments **24-hours** prior to my scheduled appointment. I understand that I will be charged and agree to pay a **$30 cancellation fee** should I fail to do so.

Signature _____ Date _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
Postcards mailed to the addresses I have provided. Emails to the addresses I have provided.
Calling, texting, leaving messages at the numbers I have provided or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

____ 7. I give Absolute Wellness permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations

____ 8. The doctor recommends that my spouse/partner/caretaker/guardian be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse/partner/caretaker/guardian contacts the office to check on my status.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Patient's Name Printed _____ Date of Birth _____

Patient's Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.chiropracticpeoria.net.

I have read and understand the information above.

Patient's Name Printed _____ Signature _____ Date _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release any information deemed appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges occurred at this office.

I authorize and assign the direct payment to you of any sum I now or hereafter owe to your office by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.

I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.

In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Patient's Name Printed _____ Signature _____ Date _____