Welcome To Buchar Family 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

___Headaches/Migraines
___Fractured Bones
___Swollen Painful Joints
___Anemia
___Pain w/ Cough / Sneeze
___Heart Problems
___Prostate Problems
___Dizziness/Vertigo
___Fatigue
___Colon Trouble
___Cold feet
___Foot Problems
___Cold Sweats
___High Blood pressure

___Hip Pain R / L
___Arthritis
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Stroke
___Kidney Trouble
___Buzzing/Ringing in ears
___Depression
___Sleeping Problems
___Bed Wetting
___Shortness of Breath
___Cancer (Type) _____
___PMS

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both

___Neck Stiffness/ Pain
___Frequent Colds / Flu
___Skin Problems
___Blurred Vision R / L
___Lung Problems
___Gall Bladder Problems
___Loss of Smell
___Sinus Problems/Allergies
___ Irritability/Mood Swings
___Cold Hands
___Recurring Infection
___Hot Flashes
___Problems Urinating
___Menopause

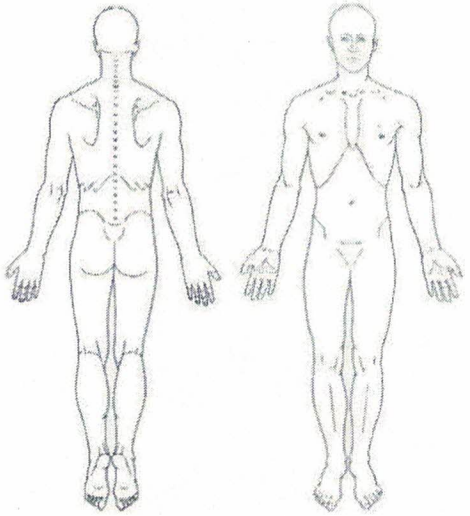
___Back Stiffness/Pain
___Diabetes
___Smoking
___Double Vision R / L
___Loss of Taste
___Digestive Problems
___Loss of Balance
___Nervousness/Anxiety
___Tension/Stress
___Stomach Upset
___Diarrhea/Constip./Gas
___Jaw/TMJ Problems
___Heartburn/Reflux
___Ulcers

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

Please mark on the diagram below the area of discomfort.



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

_____

_____

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/subluxaton getting better, worse, or staying the same? _____

❑ Worse AM ❑ Worse PM ❑ Worse W/ Activity ❑ Worse Sleeping

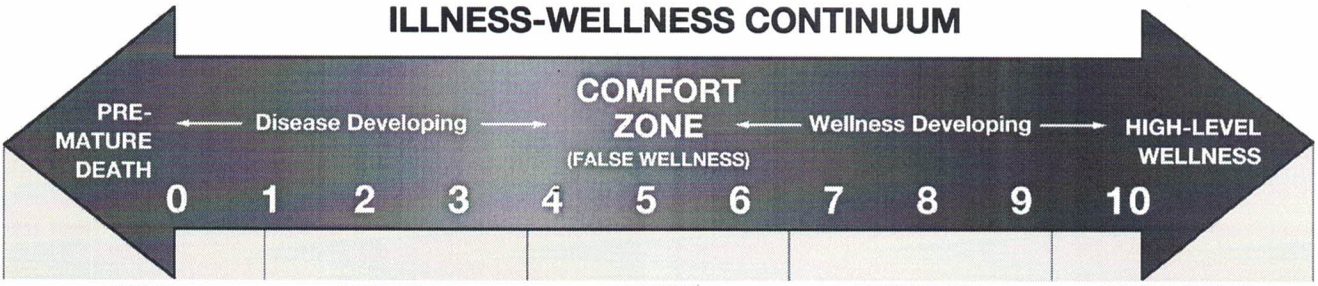
Please Mark the Diagram Accordingly Above:
R=Radiating B=Burning D=Dull A=Aching S=Sharp
N=Numbness T=Tingling

❑ 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

ILLNESS-WELLNESS CONTINUUM



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications	Symptoms	No symptoms	Regular exercise	100% function
Poor quality of life	Drug therapy	Nutrition inconsistent	Good nutrition	Continuous development
Potential becomes limited	Surgery	Exercise sporadic	Wellness education	Active participation
Body has limited function	Losing normal function	Health not a high priority	Minimal nerve interference	Wellness lifestyle

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	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Changing Positions	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading/Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ 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 expereinced: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 reoccurence)

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? _____

buchar family chiropractic
Natural Health for life!

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							

Buchar 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 Buchar 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 : **BUCHAR 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 herby indemnify and hold harmless the physicians, and other healthcare professionals who act in reliance upon this authorization.

_____ ____/____/____ ☐ *Witness Initials*

Parent/Guardian's Signature Date

Buchar 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 **P**ersonal **H**ealth **I**nformation. 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'** 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 apprize 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

Buchar Wellness Center *NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....*

I have received a copy of Buchar 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	