# Freedom Wellness Center

## PATIENT INFO

Name:
(LAST) (MI) (FIRST)

Address:
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec #: - -

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address:
(STREET) (CITY) (STATE) (ZIP)

How did you hear about us: Primary Care Physician:

## INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different from Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

**I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.**

**Patient/Guardian Signature** **Date:**

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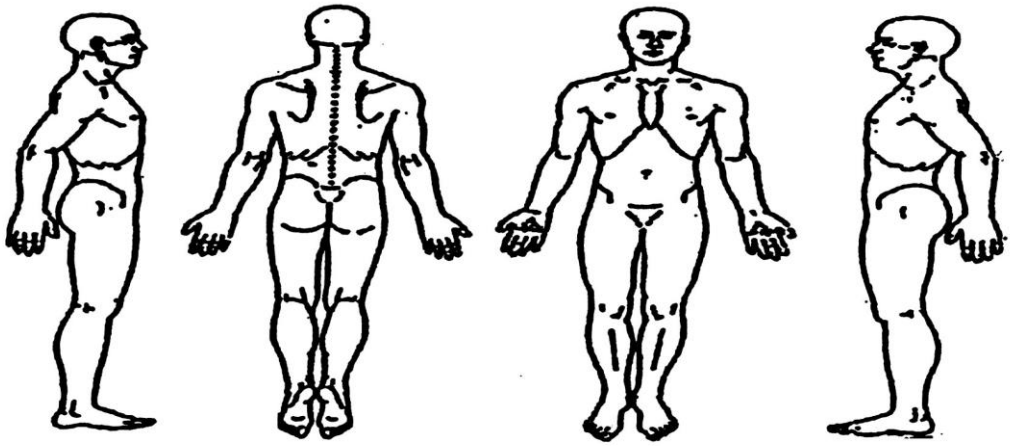
## PATIENT INTAKE FORM

Patient Name: _____ Date: _____

**1. Today's problem will be filed as:** □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

**2. What is your primary area of concern/ pain?** _____

**3. Indicate on the drawings below where you have pain/symptoms:**



**4. How would you describe the type of pain?**

| | |
|---|---|
| □ Sharp | □ Numb |
| □ Dull | □ Tingly |
| □ Diffuse | □ Sharp with motion |
| □ Achy | □ Shooting with motion |
| □ Burning | □ Stabbing with motion |
| □ Shooting | □ Electric-like with motion |
| □ Stiff | □ Other: _____ |

**5. How long have you had this problem?** _____

**6. How do you think your problem began?** _____

**7. How often do you experience your symptoms?**

| | |
|---|---|
| □ Constantly (76-100% of the Time) | □ Occasionally (26-50% of the Time) |
| □ Frequently (51-75% of the Time) | □ Intermittently (1-25% of the Time) |

**8. On a scale from 0-10 (10 being the worst), how would you rate your pain?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle)*

**9. What aggravates your problem?** _____

**10. What alleviates your problem?** _____

**11. How are your symptoms changing with time?**

□ Getting worse □ Staying the same □ Getting better

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**12. What is your: Height _____ Weight _____ Date of Birth _____**

**Occupation _____**

**13. How would you rate your overall health?**
□ Excellent □ Very Good □ Good □ Fair □ Poor

**14. Rate your level of exercise activity:**
□ Strenuous □ Moderate □ Light □ None

**15. Indicate if you suffer from or have immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

**16. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.**

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ Tobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependence |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnormal Weight Gain/Loss | | |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | **Females Only** | |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | □ | □ Birth Control Pills |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Hormonal Replacement |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Pregnancy |
| □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder | | |
| □ | □ Cancer | □ | □ General Fatigue | | |
| □ | □ Tumor | □ | □ Muscular Incoordination | | |
| □ | □ Asthma | □ | □ Visual Disturbances | | |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | | |

**17. List all prescription and over-the-counter medications you are currently taking:**

_____

_____

**18. List all nutritional supplements you are currently taking:**

_____

_____

**19. List all surgical procedures you have undergone:**

# Freedom Wellness Center

_____

_____

**20. What activities do you do at work?**

| | | | |
|---|---|---|---|
| Sit | □ Most of the day | □ Half of the day | □ A little of the day |
| Stand | □ Most of the day | □ Half of the day | □ A little of the day |
| Computer Work | □ Most of the day | □ Half of the day | □ A little of the day |
| On the Phone | □ Most of the day | □ Half of the day | □ A little of the day |
| Drive | □ Most of the day | □ Half of the day | □ A little of the day |
| Other Activities | □ Perform manual labor | □ Read a lot | □ Travel frequently |

**21. What activities do you enjoy outside of work?**

_____

**22. Have you ever been hospitalized?** □ Yes □ No

If yes, why? _____

**23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc?** □ Yes □ No

If yes, what and when? _____

**24. Is there anything else you wish to let the doctor know about your visit today?** □ Yes □ No

If yes, what? _____

**Patient Signature** _____ **Date** _____

# Freedom Wellness Center

## Insurance Verification Disclosure/Agreement

Freedom Wellness Center will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

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## Freedom Wellness Center

# Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

**Stroke:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**Disk Herniations:** Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**Rib Fractures:** The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

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**Physical Therapy Burns:** Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

**Dry Needling:** Risks include infection, bleeding, allergic reaction, increased pain, nerve damage involving temporary or permanent pain, numbness, weakness, paralysis, death, air in lung requiring chest tube, tissue or bone damage.

**Trigger point Injection** – Air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin.

**Joint Injections** (hip, shoulder, knee, elbow, etc.) – Bleeding, infection, allergic reaction, nerve damage, increased pain.

**Soreness:** It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____

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# Freedom Wellness Center

## HIPAA Disclosure

### Standard Authorization of Use and Disclosure of Protected Health Information

**Information to Be Used or Disclosed**

The information covered by this authorization includes:

All Patient Medical Records

**Persons Authorized to Use or Disclose Information**
Information listed above will be used or disclosed by:

Freedom Wellness Center

### Expiration Date of Authorization

This authorization is effective through __12/2017__ unless revoked or terminated by the patient or patient's personal representative.

### Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Freedom Wellness Center Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

**ASSIGNMENT OF BENEFITS**

**Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Freedom Wellness Center (Provider), as consideration for such Provider services. Patient irrevocably assigns to Freedom Wellness Center (Provider), any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Freedom Wellness Center (Provider): (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Freedom Wellness Center (Provider), and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable Assignment of Benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Freedom Wellness Center (Provider) health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Freedom Wellness Center (Provider).**

**By my signature be it known that I have read and fully understand the above contract.**

**Patient Signature_____(Print)_____**

**Custodian Parent/Legal Guardian_____(Print)_____**

**Witness_____(Print)_____**

**Date_____**