PEAK WELLNESS
CHIROPRACTIC AND NUTRITION

Confidential Patient Case History

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond in a positive way, we will not accept your case.

ABOUT YOU:

Name (First & Last): _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____ Birthdate: _____

Social Security #: _____ Occupation: _____

Business Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ It's Complicated ☐ Partnership

Spouse/Partner's Name: _____ Emergency Contact: _____

Emergency Contact Phone #: _____ Relationship: _____

How did you hear about us? _____

REASON FOR YOUR VISIT:

Have you ever been to a Chiropractor before? ☐ Yes ☐ No Name/State: _____

What is the reason for your visit today (Please check all that apply)?

☐ Trauma ☐ Headache ☐ Chronic Condition ☐ Backache

☐ Other (Please List): _____

Please describe your condition or reason for your visit: _____

_____

_____

Are you currently taking any supplements and/or vitamins? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

YOUR HABITS

Tobacco Use ☐ Yes ☐ No Times per day _____

Drink Alcohol ☐ Yes ☐ No Times per day _____

Soda ☐ Yes ☐ No Times per day _____

Coffee ☐ Yes ☐ No Times per day _____

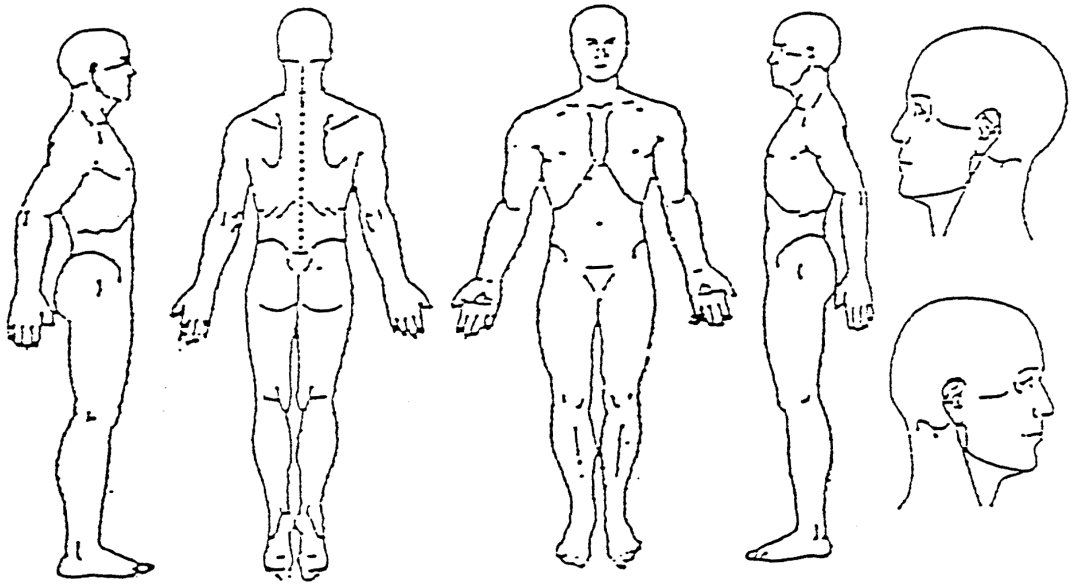
Exercise ☐ Yes ☐ No Times per week _____

Exercise type: _____

Food Irritations: _____

Sleep Position ☐ Back ☐ Side ☐ Stomach

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



PLEASE CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN

0 1 2 3 4 5 6 7 8 9 10

No pain **Moderate Pain** **Most Severe Pain**

HAVE YOU EVER SUFFERED FROM:

Migraine Headaches	☐ Yes ☐ No	Neck Pain	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Female Problems	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Digestive Disorders/Ulcers	☐ Yes ☐ No	Seizure/Stroke	☐ Yes ☐ No
Nervousness	☐ Yes ☐ No	Kidney Disease/Stones	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No		

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature of the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure with the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns, mild to severe bruising or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other Treatment Options Which Could be Considered may include the following:

- *Over-the-counter analgesics. The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.*
- *Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of theses drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.*
- *Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.*
- *Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.*

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

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Payment Policy

(A) IF YOU HAVE HEALTH INSURANCE
Which covers chiropractic care, we ask that you pay 100% of your first visit and 100% of all services as they are rendered until your deductible has been met. After your deductible has been met, we ask that your co-payment amount be paid as services are rendered. We will gladly process your insurance for your convenience.

(B) IF YOU WERE HURT ON THE JOB
We will bill the liable insurance company directly.

(C) IF YOU WERE INJURED IN AN AUTO ACCIDENT
We will bill the responsible insurance company or your attorney directly.

(D) IF YOU ARE COVERED BY MEDICARE
We request that you pay when services are rendered or make financial arrangements with our office staff. We will bill Medicare and you will be reimbursed.

(E) IF YOU DO NOT HAVE HEALTH INSURANCE
Which covers chiropractic care, we request that you pay when services are rendered or make financial arrangements with our office staff.

I authorize the doctor and staff to examine, take x-rays, treat me and do whatever they deem necessary in accordance with the state statues, for the care and management of my conditions. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Amy Thomas or Dr. Neil Thomas will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Peak Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination and treatment records, and the prognosis to my employer, my attorney or insurance company. I also understand that if a problem arises with payment of my bill and legal services are required, I will be responsible for all costs, collection costs, and legal fees incurred. **PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**

I choose plan: (circle one) A B C D E

Signature: _____ Date: _____

Social Security #: _____ Date of Birth: _____

HEALTH INSURANCE INFORMATION: Accident Date: _____

Company: _____ Insured's Name: _____
Address: _____ Insured's DOB: _____
Insured's SSN# _____ Group #: _____
Policy #:_____ Certificate #: _____

Have you filed on this condition in the last year? YES NO

CO-INSURANCE INFORMATION

Company: _____ Insured's Name: _____
Address: _____ Insured's DOB: _____
Insured's SSN#: _____ Group #: _____
Policy #: _____ Certificate #: _____

Relationship to Insured: Self Spouse Child Other

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Patient Health Information Consent Form

We care about our patients' privacy and want you to know how your Private Health Information **(PHI)** is used in this office and your rights concerning those records. Before beginning any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Health Information, we encourage you to read the HIPAA NOTICE OF PRIVACY PRACTICES available at the front desk before signing this consent.

- ✓ The patient understands and agrees to allow Peak Wellness to use their Private Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. Example: the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Peak Wellness will only release what PHI is necessary for payment.

- ✓ The patient has the right to examine and/or obtain a copy of their own health records and may request corrections. The patient may request a list of what disclosures have been made from their PHI since April 14, 2003. The patient may also request restrictions on the use of their PHI. This office is not obligated to agree to all restrictions.

- ✓ All of the above requests must be submitted in writing with a signature, date of request, date of birth or social security number, and information requested/restricted any further restrictions on the use of their PHI. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

- ✓ The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

- ✓ For your security and right to privacy, Peak Wellness has trained and abides by HIPAA privacy regulations and a privacy official has been designated to enforce all privacy procedures. We have taken all precautions to assure that your records are not readily available to those who do not need them.

- ✓ Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

- ✓ If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Peak Wellness has the right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature (If Guardian, list relationship) _____

Date _____