Office of Dr. Jason B. Jones
706 W. Ehringhaus St. Elizabeth City, NC 27909
252-335-2225 www.optimumwellnessandrehab.com

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Age: _____ Date of Birth: _____
Sex: ( ) Male ( ) Female
( ) Single ( ) Married ( ) Divorced ( ) Separated
( ) Widowed
Social Security #: _____- _____- _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Children (# and ages): _____

Type of work: _____
Insurance: Medicare ( ) Private: _____
_____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
( ) Internet ( ) Lecture ( ) Drive by ( )Website
( ) Other: _____

In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Best way to Contact You (Circle One):
Text Cell# Home# Email

Your Health Profile: Please answer all questions thoroughly

Have you had previous chiropractic care? ___Yes ___No

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What type of care did you receive (Circle all that apply)? Relief Structural Correction Wellness

Who is your Primary Care Physician (Regular MD)? _____
Can we send a report about your care to them? ( ) Yes ( ) No

How many Medical Doctor's office visits did you have in the last year?
( ) None ( ) Less that 5 ( ) More than 5 ( ) More than 10

Medical History

Please list the cause of death (including cancer, heart disease, stroke or diabetes) and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death
_____	_____	_____
_____	_____	_____

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____

Previous injuries, trauma or fractures (please give type and date): _____
_____

Doctor:_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION (required by NC Law)

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Appointment Reminders

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Patient Acknowledgement Contact ----- Circle All That Apply to You

*Cell Phone *Home Phone *Text Message *Email *All of the Above

I have read your informed consent, insurance and financial statements and privacy pledge and agree to its terms.

_____ _____

Signature of Guardian/Patient Date

INFORMED CONSENT FOR CHIROPRACTIC CARE (required by NC Law)

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. This doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

I understand that the doctor will perform an examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Be advised that at Jones Family Chiropractic, PC no cures are ever implied or promised.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

I also state that I am here for evaluation, examination, recommendations and treatment only and am here for no other purposes.

_____ _____

Signature of Guardian/Patient Date

Doctor:_____

JONES FAMILY CHIROPRACTIC, PC OFFICE POLICIES

******Please read all of these thoroughly before signing******

1. PAYMENT IS DUE IN FULL WHEN SERVICES ARE RENDERED. PRE-PAYMENTS AND PAYMENT PLANS MAY BE ACCEPTED ON A CASE-BY-CASE BASIS. Payments can be made by cash, check, debit card, credit card, health savings, flex spending accounts and/or Care Credit.
2. In the event that a patient's account is delinquent, an overdue notice will be sent his/her address on file. If payment is not received within 90 days of the notice date, a 1.5% per month service charge will be incurred until paid in full. We reserve the right to retroactively add interest to the date of release of the patient from care.
3. There will be an additional $25 fee for returned or NSF checks.
4. Copies of X-rays are $15 per CD. X-ray written reports are $125 per section of films.

IMPORTANT INSURANCE NOTIFICATIONS – AGAIN PLEASE THOROUGHLY

- Your insurance is an agreement between you and your insurance company. Upon verification of your insurance we will be informed that "VERIFICATION IS NOT A GUARANTEE OF PAYMENT" We hold to this statement. Decisions about payment will be made when the claim is reviewed by your insurance company. **(initial) _____**

- Jones Family Chiropractic, PC is **NOT a participating provider** with BCBS, Aetna, Cigna, Coventry, Federal BCBS, Medcost, Optima Health, United Health Care and any other insurance not listed other than Medicare. We will provide appropriate forms for self-filing. **(initial) _____**

  - Jones Family Chiropractic, PC will print out your Health Insurance Claim Form for you on the last Monday of each month. Please initial here if you would like your claims printed out **(initial) _____. Except for Medicare, you are responsible for your own insurance re-imbursement. Payments are due at the agreed upon schedule.**
  - We **DO NOT DO ANY PRE-AUTHORIZATION** for any insurance company.
  - All insurance information and contact information must be given to our office at the time of the patients' first visit. If any of this information changes, it is the patient's responsibility to notify the front desk immediately.
  - If the patient's insurance has a deductible, it will be assessed based on the charges incurred at this office.
  - Our office fees may be different than your insurance companies allowable.
  - This office does not guarantee any insurance company will or should make partial or full payment of fees charged. All claims are subject to review for coverage. Verification is not a guarantee of payment.
  - **(initial) _____**It is not this office's obligation to enter into a dispute with an insurance company concerning payment.
  - **MEDICARE ONLY: (initial) _____** Medicare covers spinal adjustments only and **does not cover** any exams, x-rays, re exams, modalities, extremity adjustments, support or supplements. If you receive any of these non- covered services or supplements, it is your responsibility to pay the complete cost at the time received. Medicare also does not cover Maintenance or Wellness care. If you choose these services, these are paid out of pocket at the office rate.

Patient Signature _____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Jones Family Chiropractic, PC office Notice of Privacy Practices.

_____	_____	_____
Print Name	Signature	Date

Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ Emergency situation prevented us from obtaining acknowledgement
__ Other

(please specify)

Doctor:_____

Medications (including over the counter drugs): **PLEASE PRESENT LIST TO FRONT DESK IF YOU HAVE ONE**.

Medication & Dosage	Reason for taking	How long have you been taking?
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking	How long have you been taking?
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Allergies: _____
_____

Lifestyle/Social History—Please answer all questions thoroughly

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke? Y N If yes, how much? _____
Do you drink alcohol? Y N If yes, how much? _____
Do you drink coffee? Y N If yes, how much? _____
Do you drink tea? Y N If yes, how much? _____
Daily water intake in glasses: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+
Daily servings of vegetables in cups: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+
Daily servings of fruits in cups: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+
Do you follow a particular diet (paleo, ketogenic, low fat, diabetic)? YES NO Please List_____
How regularly do you exercise? ( ) never ( ) occasionally ( ) ___x/week ( ) daily
What kind of exercise do you do? _____
How many hours of sleep do you get on average? _____ Quality of sleep (1-10)? _____
What position do you regularly sleep in? Back Side Stomach
How many hours per day do you sit on average? _____
Do you work around/inhale chemicals? Yes No Explain: _____
On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational	1	2	3	4	5	6	7	8	9	10
Personal	1	2	3	4	5	6	7	8	9	10

Are you currently going through a high STRESS situation? Yes No If Yes, for how long? _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____

When was your last period? _____

Are you pregnant or Nursing? ( ) Yes ( ) No ( ) Not sure Menopause? ( ) Yes ( ) No ( ) Not sure

Have you ever served in the US Military? Yes No If Yes, What branch(es) and what years did you serve?
_____

Doctor:_____

Please describe below your reasons for seeking care in our office. Please be as detailed as possible: IF YOU ARE HERE FOR WELLNESS CARE AND HAVE NO SYMPTOMS, SKIP THIS PAGE

Primary Complaint (*List one only*): _____

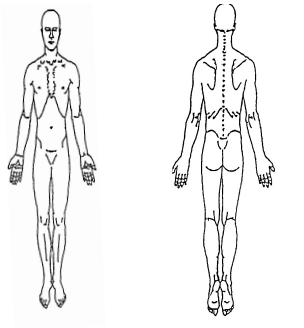
What was the date you **first experienced** this problem? _____ Most Recent Onset Date?_____

How did this problem first begin? Fall Accident Stressful Situation Other _____
_____

How would you describe the symptoms (Circle all that apply)? Burning Stabbing Aching Sharp Tingling Numb
Other: _____

On a scale of 1-10, how bad is it? (with 10 being worst): 1 2 3 4 5 6 7 8 9 10

Draw your Symptoms below



Is this problem: **In the AM:** ( ) worse? ( ) better? **In the PM:** ( ) worse? ( ) better?

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

Which activities aggravate your condition (Circle all that apply)? Sitting * Standing * Walking * Lifting * Working * Exercising * Lying Down * Other
_____

What have you done for this condition? Tylenol * Advil * Aleve * Prescription Drugs * Muscle Rubs * Heat * Ice * Stretching * Exercise * Home Remedies * Physical Therapy * Surgery *Other _____

How helpful were the above? (Circle One) Not helpful * Somewhat helpful * Moderately helpful * Very helpful

Have you seen any other doctors for this problem? Y N If yes, who and what were their recommendations?
_____

Stress History

Please indicate whether you have **ever USED, HAD OR EXPERIENCED** any of the following. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional) _____		

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident(s) How many? _____	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional)	Y	N

Doctor:_____

Functional Rating Index

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____ _____
Signature Date

Doctor:_____

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

Doctor:_____