TOTAL WELLNESS CHIROPRACTIC & HOLISTIC CARE

PATIENT REGISTRATION AND MEDICAL HISTORY

➢ *PATIENT INFORMATION* ** PLEASE PRINT **

CELL NUMBER WILL BE USED FOR APPOINTMENT REMINDER TEXTS

Today's Date: _____

Name: _____
First Name Middle Initial Last Name

Preferred Name/Nickname: _____

Date of birth: _____ Age: _____

☐ Male ☐ Female

Address:_____

City: _____

State: _____ Zip Code _____

Phone #1: (____) _____ - _____ ☐ cell ☐ home ☐ other

Phone #2: (____) _____ - _____ ☐ cell ☐ home ☐ other

Email: _____

☐ Minor ☐ Single ☐ Married ☐ Other

Employer/School: _____

Occupation: _____

In case of emergency, contact: _____

Phone: (___) _____-_____ Relationship: _____

Whom may we thank for referring you? _____

➢ *FINANCIAL AGREEMENT & INFORMATION*

Is a parent or guardian financially responsible? ☐ YES ☐ NO Name & relationship to patient: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), assign directly to Dr. Jon Lindsey all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am financially responsible for all charges for services received whether or not they are covered or paid by insurance.* I authorize the use of my signature on all insurance submissions. The above-named doctor may use my personal health information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or three years from the date below. *There will be a $25 administrative fee for all returned checks.*

____/____/_____ _____ _____ _____

Date Signed | Please print name of patient or parent/guardian | ***Signature of patient or parent/guardian*** | Relationship to patient

If you would like us to bill your insurance, please write the insurance company name(s) below and give us your insurance card(s) so we can make a photo copy: Primary _____ Secondary _____

➢ *ACCIDENT INFORMATION*

Is your current condition due to an accident? ☐ Yes ☐ No ☐ Unsure

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other Date & Location of Accident: _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp.

Name of Auto Insurance, Employer, or Attorney (if applicable): _____

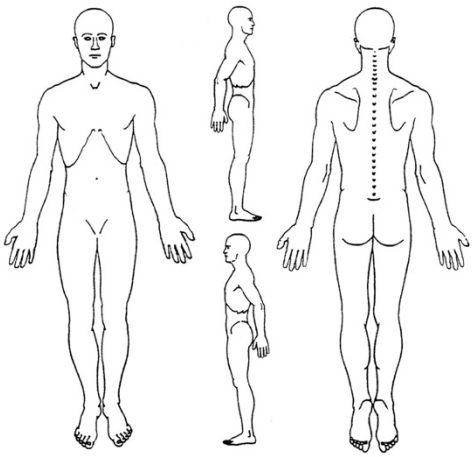
➢ *PATIENT CONDITION*

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an **X** on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least) to 10 (severe): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

➢ *MEDICAL HISTORY*

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

Previous Chiropractic Care: ☐ Yes ☐ No If yes, approximate date last treated & location: _____

Condition Treated: _____ Outcome: _____

Have you had any imaging done for your condition? X-rays/MRI/CT/Other: _____ Where? _____

Please check the box to indicate if you have had (or currently have) any of the following:

☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Anxiety	☐ Appendicitis
☐ Arthritis	☐ Asthma	☐ Breast Lump	☐ Bronchitis	☐ Bruise Easily
☐ Cancer	☐ Cataracts	☐ Chronic Stress	☐ Depression	☐ Diabetes
☐ Eczema	☐ Fatigue	☐ Fibromyalgia	☐ Fractures	☐ Glaucoma
☐ Goiter	☐ Gout	☐ Heart Attack	☐ Heartburn	☐ Heart Disease
☐ Hernia	☐ Herniated Disk	☐ High Blood Pressure	☐ High Cholesterol	☐ Insomnia
☐ Kidney Disease	☐ Migraines	☐ Miscarriage	☐ Osteoporosis	☐ Plantar Fasciitis
☐ Pneumonia	☐ Prostate Problem	☐ Psychiatric Care	☐ Rheumatoid Arthritis	☐ Stroke
☐ Suicide Attempt	☐ Swelling Hands/Feet	☐ Thyroid Problems	☐ Tumors, Growths	☐ Ulcers
☐ Vaginal Infections	☐ Other: _____	_____	_____	

Injuries/Surgeries You Have Had (description and approximate date):

Falls: _____ _____

Head Injuries: _____ _____

Broken Bones: _____ _____

Dislocations: _____ _____

Surgeries: _____ _____

Hospitalizations: _____ _____

List All Known Allergies: _____

➢ *GENERAL HEALTH & LIFESTYLE*

Are you currently under the care of a physician or other healthcare professionals? If yes, please list their name and the approximate date of your most recent visit: _____

Are you pregnant: ☐ Yes ☐ No If yes, estimated due date: _____

How is most of your day spent? ☐ Standing ☐ Sitting ☐ Other: _____

Do you exercise? ☐ Daily ☐ Often ☐ Rarely ☐ Never

Do you use tobacco? ☐ Yes ☐ No ☐ Previous User If yes, how often? _____

Do you drink soda? ☐ Yes ☐ No If yes, how many fluid ounces per day? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Previous User If yes, how often? _____

How much sleep do you average per night? _____ Hours

Current Medications & Supplements (prescription and OTC): _____ _____

_____ _____ _____ _____

What would be the most significant thing you could do to improve your health? _____

In addition to the main reason for your visit today, what additional health goals or concerns do you have? _____

_____

➢ *Privacy Policy & Communications*

Your privacy is very important to us. We collect nonpublic personal information about you to assist you in your health care. In order to protect your privacy, we have adopted precise privacy measures to ensure that any and all information you share with us is protected. ***We release information that you share with us only upon your prior approval or as required by law*.**

I authorize Total Wellness Chiropractic to share my healthcare information with the following people and/or medical facilities:

(for example: your spouse/partner/or other family member, primary care doctor, referring doctor/facility)

Primary Healthcare Provider (if so desired): _____

Other (please print name): _____ *Relationship:* _____

Other (please print name): _____ *Relationship:* _____

As required by HIPAA Privacy Regulations, Total Wellness Chiropractic & Holistic Care has made me aware of their privacy practices. I understand that Total Wellness Chiropractic & Holistic Care follows HIPAA guidelines. I acknowledge that I can request a copy of their "Notice of Privacy Practices" at any time, either now or in the future.

Patient Name (printed): _____

Patient/Guardian ***Signature***: _____ Date Signed: _____

➢ *Consent to Care & Treatment Results*

I hereby request and consent to the performance of physical medicine procedures, chiropractic adjustments, muscle therapies, and other usual and customary medical procedures, including examination tests and other physical therapy techniques, on me (or on the patient named below for whom I am legally responsible) which are recommended by the Doctors of Chiropractic and/or other therapists of Total Wellness Chiropractic & Holistic Care who render treatment or recommendations to me.

I understand that, as with any health care procedures, there are certain complications that may arise during a physical medicine visit, chiropractic adjustment, or therapy session. The clinical procedures performed are usually beneficial to the patient and seldom cause any problem. In rare cases the following may occur, but are not limited to: fractures, stroke, disc injuries, bruising, tenderness from treatment, discomfort from procedures , rare reactions from taping, and sprains/strains.

I have relayed all pertinent health information to the best of my knowledge, and I assume all responsibility/liability if I do not report on the health forms any current or past medical history, illnesses, medications, or allergies. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely on the staff's expertise and exercise judgement during the course of the procedures at the time and based upon the facts then known, and in my best interest. Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume the risks listed above.

I understand that I will have the opportunity to ask questions and discuss with the doctors of Total Wellness Chiropractic & Holistic Care the nature, purpose, risks, and other recommended procedures and that it is my responsibility to ensure that my questions are answered to my satisfaction. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read (or have had read to me) the above explanation. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo treatment recommended and hereby give my consent to said treatment. I intend this consent form to cover the entire course of treatment for my (or the patient whom I am legally responsible for) present condition and for any future conditions for which I may seek treatment.

*****Please do not sign until you have read and understood the above information.*****

Patient Name (printed): _____

Patient/Guardian ***Signature***: _____ Date Signed: _____