WISE CHIROPRACTIC

PATIENT APPLICATION FOR TREATMENT

First Name: _____ M.I.: _____ Last Name: _____

What do you prefer to be called: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell#: _____ Other: _____

SS#: _____ Sex: _____ Single\Married\Divorced\Widow

Spouse Name: _____ Email: _____

Emergency Contact: _____ T#: _____

How did you hear about us? _____

Who can we thank for the referral? _____

Who is your Primary Care Doctor? _____

Do you have Medicare? □ Yes □ No

Primary Insurance: _____ Secondary Insurance: _____

Please hand the front desk all of your insurance cards
They will copy them & return back to you

Insurance Verification and **authorization** is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Wise Chiropractic, Inc. to release any information regarding my treatment to my insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature Date Parent Signature (if patient is a minor)

WISE CHIROPRACTIC

INFORMED CONSENT

I understand and I am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to: muscle strains, sprains, fractures, dislocation, intervertebral disc injury and cardiovascular accident. I understand that **Dr. Jonathan C. Wise** will not be able to anticipate all potential complications but will reply on clinical expertise and judgment to determine the correct course of treatment which will be in my best interest considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommendations evaluation and treatment procedures at any time.

I have read and understand the preceding statement and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative and exercise/rehabilitation therapies as deemed appropriate by Dr. Jonathan C. Wise. If at any time I have further questions or decide not to continue to consent in treatment, I understand I have the right and it is my duty to notify my doctor.

_____	_____	_____
Print Patient Name	Signature	Date

If patient is a minor:

_____	_____	_____
Print Parent/Guardian Name	Signature	Date

WISE CHIROPRACTIC

HEALTH INFORMATION PROTECTION PORTABILITY ACT (HIPPA)

THIS NOTICE DESCRIBED HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at **WISE CHIROPRACTIC, INC.,** we may use or disclose personal and health related information about you in the following ways:

- Your personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer (if they are responsible for the payment of your services).
- Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, newsletters and birthday correspondence to provide information about alternatives to your present care or for other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenue associated with your care. Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or regarding the status on your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preference.
You have the right to inspect and/or copy your health information for seven years or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice; we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health records in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclose by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rights.

If you have a concern regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our **OFFICE MANAGER**. If you would like further information about our policies and practices please contact our **OFFICE MANAGER**. This notice is effective as of ____/____/20__. This notice and any altercations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

WISE CHIROPRACTIC

PATIENT HISTORY

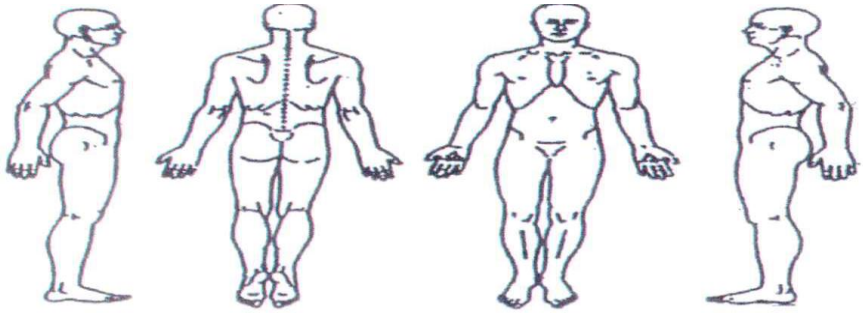
Patient Name: _____ Date: _____

Describe your **PRIMARY** symptoms: _____

List other symptoms: _____

Are your symptoms related to: □ Auto Accident □ Workman's Comp.

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



How often do you experience your symptoms?

□ Constant (76-100% of the time) □ Frequent (51-75% of the time)
□ Occasional (26-50% of the time) □ intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ numb □ dull □ Tingly □ diffuse □ Achy
□ Burning □ shooting □ Stiff □ Sharp w/ motion □ stabbing w/ motion
□ shooting w/ motion □ Electric like □ Other: _____

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate your symptoms with activity?

0 1 2 3 4 5 6 7 8 9 10

Using a scale from 0 - 10 (10 being the worst), how would you rate your symptoms w/out activity?

0 1 2 3 4 5 6 7 8 9 10

List your hobbies: _____

How much has your symptoms interfered with your social activities\hobbies\work?

□ Not at all □A little bit □ moderately □ Quite a bit □ extremely

Who else have you seen for these symptoms?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician
□ Orthopedist □ Massage Therapist □ Physical Therapist □ Other: _____

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Have you had x-rays/MRI/CT scan taken that are related to your symptoms? □ Yes □ No

Where: _____ Who Ordered Them: _____

What aggravates your symptoms? _____

What concerns you the most about your symptoms\what do they prevent you from doing?
_____

What is your: **Height _____** **Weight _____**

For Females only: Are you Pregnant? □ Yes □ No Last Menstrual Period: _____

How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the followings:

□ Rheumatoid □ Diabetes □ Lupus □ Cancer □ Als □ Heart Problems

List all medications you are currently taking: _____
_____
_____

List all over-the-counter medications you are currently taking: _____
_____
_____

List all surgical procedures you have had: _____
_____
_____

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Please check the following if you have had in the past or present.

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

What activities do you do during the day?

□ 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

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential and I understand that it is my responsibility to inform this office of any changes in my medical status.

_____	_____	_____
Print Patient Name	Signature	Date