The Health and Wellness Center

Today's Date _____

PATIENT INFORMATION

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible.

PERSONAL INFORMATION

Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Height: _____ Weight: _____
Home Phone: _____ Cell Phone: _____ Gender: M F
Date of Birth: ____ / ____ / ____ Age: _____ Marital Status: __ M __ S __ W __ D # of Children: _____
E-mail address: _____ SSN: _____-____- _____
Occupation: _____ Business/Employer: _____ Work Phone: _____
Spouse's Name: _____ Spouse's Phone: _____
In Case of Emergency Notify: _____ Phone: _____
Name of Family Physician: _____
Who referred you to our office? _____

CURRENT HEALTH CONDITION

Main or Primary Complaint(s): _____
_____
_____
How Severe Is This Problem: __ Mild __ Moderate __ Severe Previous Occurrences: __ Yes __ No
When Did This Condition Begin: _____
Other Doctors Seen For this Complaint: _____
Previous Doctor's Opinion/Diagnosis: _____
_____
Is Condition: __ Job Related __ Auto Related __ Injury Other: _____
Other or Secondary Complaints: _____
_____
Other Health Problems: __ Yes __ No If "Yes", please describe: _____
Drugs or Medicines Now Taking:
__ Pain Killers / Muscle Relaxers __ Blood Pressure Medicine __ Stomach Medicine __ Tranquilizers
__ Antibiotics Other: _____

PAST HEALTH HISTORY

Major Surgeries/Operations: ___ Head ___ Neck/Throat ___ Chest/Heart/Lung ___ Back ___ Abdominal
Other: _____
Previous Fractures or Broken Bones: __ Yes __ No What: _____
Previous fall or Accidents: __ Yes __ No When: _____
Previous Hospitalization: __ Yes __ No Why: _____
Previous Chiropractic Care: __ Yes __ No Doctor: _____
Has Anyone Else In Your Family Had A Similar Problem? __ Yes __ No
Do You Participate In Any Sports or Exercise Programs? __ Yes __ No
Were treated by a physician for any condition in the last 12 months? __ Yes __ No Condition? _____
Are you allergic to any medication? __ Yes __ No What kind? _____

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as carefully as possible.

Check any of the following that applies to you:

_ Polio
_ Diabetes
_ AIDS or ARC
_ Frequent Illnesses
_ High Blood Press.
_ Arthritis
_ Epilepsy
_ Heart Disease
_ Asthma
_ Arthritis
_ Chronic Fatigue
_ Cancer
_ Allergies
_ Bowel/Bladder
_ Other: _____

INTAKE or *USE*

_ Alcohol
_ Prescribed Drugs
_ Recreational Drugs
_ Pain Reliever
_ Tobacco

Check any problem that you have had in the past 6 months:

Muscles-Skeleton

_ Low Back Pain
_ Pain Between Shoulders
_ Neck Pain
_ Arm Pain
_ Joint Pain/Stiffness
_ Problems Walking
_ Difficulty Chewing - TMJ
_ General *Stiffness*

Circulation-Breathing

_ Chest Pain
_ Shortness of Breath
_ Blood Pressure Problems
_ Irregular Heart Rate
_ Heart Problems
_ Lung Problems
_ Stroke

Eye-Ear-Nose-Throat

_ Visual Disturbances
_ Dental Problems
_ Sore Throat
_ Ear Aches
_ Difficulty Hearing
_ Stuffy Nose
_ Sinus Drainage/Pain
_ Pain - Forehead or Face

Nerve System

_ Headaches
_ Nervousness
_ Numbness/Tingling
_ Muscular Weakness
_ Dizziness
_ Forgetfulness
_ Depression
_ Fainting
_ Convulsions/Seizures
_ Cold Hands Feet
_ Stress
_ Shaking/Tremors

Digestion-Elimination

_ Poor Appetite
_ Excessive Thirst
_ Frequent Nausea
_ Diarrhea
_ Constipation
_ Hemorrhoids
_ Weight Loss/Gain
_ Gas/Bloating
_ Heartburn
_ Change in Stools

Urinary-Genitals

_ Pain with Urination
_ Infrequent Urination
_ Frequent Urination
_ Weak Urine Stream
_ Loss of Bladder Control
_ Pain in Genitals

Female Only

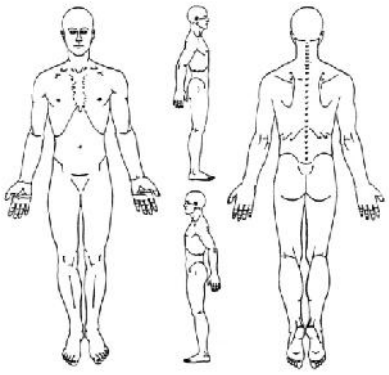
_ Menstrual Pain/Irregularity
_ Low Back Pain w/ Periods
_ Breast Pain/Lumps

Are You Pregnant?

_ *Yes* _ *No* _ *Not Sure*

Please mark your areas of complaint:

(X) Pain
(0) Spasm
(*) Numb



Rate the level of pain/discomfort on a scale from 0-10 (10 being extreme pain on the body to the left.

How would you rate your eating habits? _ Excellent _ Good _ Poor
Do you follow a specific nutritional program? _ Yes _ No
Would you like help with nutrition/diet/supplements? _ Yes _ No
How well do you sleep? _ Excellent _ Good _ Restless _ Can't sleep
Hours of sleep daily? ___ Do you feel rested in the morning? _ Yes _ No
How is your energy overall? _ Great _ Ok _ Low _ Sporadic/Fatigued
How do you feel your immune system is? _ Strong _ Ok _ Low
What do you hope to receive from care in our clinic? _____
_____

I hereby request and consent to the administration of diagnostic procedures, chiropractic adjustments and other chiropractic procedures including, but not limited to, various modes of physical therapy and diagnostic x-rays administered by the staff at The Health and Wellness Center. I have been informed of the benefits and risks of chiropractic care and understand it is my responsibility to ask questions. I attest that the information completed by me on this form is correct and true to the best of my knowledge and agree to notify this office in the event of any change. Payment is expected for all office visits, services, treatments, procedures, and products purchased at the time of each visit unless other arrangements have been made with the business office personnel.

Patient's/Guardian's Signature: _____ Date: _____

THE HEALTH AND WELLNESS CENTER
Patient Consent Form / Terms of Acceptance

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In the course of Chiropractic Healthcare, it is essential for the physician and patient to work towards the same objective. As a patient in our office, you should know and understand the goal and methods used to provide chiropractic healthcare in this office in order to avoid confusion or disappointment.

Health:

Dorland's Medical Dictionary defines "Health" as: "…not merely the absence of disease and symptoms, but a state of optimal physical, mental and social well-being."

Vertebral Subluxation:

"…a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve impulses and interference to the transmission of the nerve impulses, which can impair the body's ability to achieve its health potential."

We diagnose and treat those conditions, which we relate to be bio-mechanical, neuro-musculo-skeletal based. However if during the course of a chiropractic examination we encounter unusual findings or findings which we believe can be better examined or treated by any other type of healthcare provider, we will advise or refer you. If you desire, you may then seek the advice, diagnosis, and treatment for those finding for any healthcare provider of your own choosing who specializes in the area.

We do not offer advice regarding treatment prescribed by other healthcare professionals.

The Adjustment:

The primary method of treatment used in the office is the adjustment, otherwise known as "chiropractic manipulative therapy" An adjustment is specific application of force either by hand or by handheld instrument to a joint to improve a lack of joint play in order to affect the body's physiological healing response.

Additional therapies may be utilized depending on the nature and need of a given health care situation.

Our Objective:

Our primary practice objective is to eliminate, by adjustment, the subluxation(s) found and to aid the body's healing response by the use or application of physical modalities and procedures. Other therapies or modalities, be they nutrition, physical therapy, massage therapy, etc., are adjunctive (supportive) to the adjustment.

"Unproven" Services:

While the chiropractic adjustment is our main service, our clinic utilizes a variety of different therapies, treatments and testing procedures to aid our doctor in helping our patients achieve the best health possible.

Being that not all procedures are common to chiropractic, the Colorado State Board of Chiropractic Examiners requires that we inform you which services they would consider to be "unproven." "Unproven" therapies can be highly successful, but do not fall under the State's definition of chiropractic.

Some of the "unproven" services offered in this clinic are Nambudripad's Allergy Elimination Technique, Body Restoration Technique, Emotional Freedom Technique, Muscle Response Testing, etc. Other techniques or procedures may be verbally reviewed with the patient.

I, _____ (PRINT NAME) have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore authorize and consent to receiving any treatment deemed appropriate and beneficial, by the doctor and/or staff, at this clinic, be it considered proven or unproven.

_____ _____

Patient Signature Date

The Health and Wellness Center
Notice of Privacy Practices (Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSES HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visiting to your insurance company for payment.
- Health care operations include the business aspect of running out practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminder or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke authorization in writing and we are required to honor and abide by that written request. Except to the extent that we have already taken actions relying on your authorization

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures or protected health information. Including those related to disclosures to family member, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I have received a Notice of Privacy Practices form from The Health and Wellness Center and have read and understood it. This acknowledges form will be filed.

Name: (Please Print) Date of Birth:

Signature: Today's Date:

MAKE A COPY OF THIS FORM FOR YOUR RECORDS