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Your Facts

C1

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Date of Birth: ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

Employer: _____ **Work #:** _____ **Ext:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

Are you currently taking any medications or supplements? (*Please include regularly used over the counter medications*).....

Medication Name	Dosage and Frequency

Supplement Name	Dosage and Frequency

Do you have any medication, food, or environment allergies?

Medication, Food or Location	Reaction

Please list 3 major health goals in order of priority:

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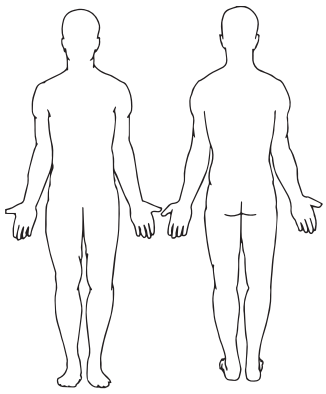
Your Consultation

C2

Name: _____ **Date of Birth:** _____ **Date:** _____

Pain Location



Front **Back**

Present Condition

List conditions in order of concern and mark location of pain.

(minor) **Pain Scale** *(extreme)*
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1. _____
2. _____
3. _____
4. _____
5. _____

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse

Explain: _____

What makes pain better? _____

Worse? _____

Difficult activities: _____

Who Have You Seen:

Who have you seen for your symptoms, and when? ***Date***

Chiropractor: _____

_____

Medical Doctor: _____

_____

Physical Therapist: _____

_____

Other: _____

_____

Have You Had:

Blood analysis	☐ Yes	☐ No	_____ When
Blood pressure check	☐ Yes	☐ No	_____ When
Bone density	☐ Yes	☐ No	_____ When
Eye exam	☐ Yes	☐ No	_____ When
Feelings of hopelessness	☐ Yes	☐ No	_____ When
Feelings of depression	☐ Yes	☐ No	_____ When
Feelings of anxiety	☐ Yes	☐ No	_____ When
Feelings of panic	☐ Yes	☐ No	_____ When
MRI	☐ Yes	☐ No	_____ When
Spinal x-ray	☐ Yes	☐ No	_____ When

Current Symptoms

1
- ☐ Knee Pain
- ☐ Leg Cramps
- ☐ Numbness in Toes
- ☐ Tingling in Legs
- ☐ Weakness In Legs

2
- ☐ Urinating Issues
- ☐ Lower Back Pain
- ☐ Ringing in Ears

3
- ☐ Bladder Infections
- ☐ Belching
- ☐ Constipation

3
- ☐ Indigestion
- ☐ Vomiting

4
- ☐ Arm Pain
- ☐ Circulatory Problems
- ☐ Hands Cold
- ☐ Mid-Back Pain
- ☐ Numbness in Fingers
- ☐ Shortness of Breath
- ☐ Shoulder Pain
- ☐ Tingling in Arms

5
- ☐ Back Pain
- ☐ Dizziness
- ☐ Hair Loss
- ☐ Hay fever
- ☐ Hives
- ☐ Loss of Balance/Dizzy
- ☐ Neck Pain/Stiffness
- ☐ Nervousness

6
- ☐ Bruise Easily
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Frequent Colds
- ☐ Hemorrhoids

6
- ☐ Loss of Smell/Taste
- ☐ Muscle Spasms
- ☐ Sight Sensitivity
- ☐ Sinus Problems

7
- ☐ Cold/Hot Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Joints Swelling/Pain
- ☐ Sleep Problems
- ☐ Stress
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

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Your History

C3

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis - *Type*_____	☐	☐	☐	☐	☐
Birth Trauma	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐
Cancer -*Type*_____	☐	☐	☐	☐	☐
Cholesterol - High	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addictions	☐	☐	☐	☐	☐
Eye Condition	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder	☐	☐	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	☐	☐
Glasses/contacts	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
HIV/AIDS	☐	☐	☐	☐	☐
Immune System - Weak	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐
Scarlet Fever	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Patterns

Mark those that apply and amount if applicable.

Example: Lift Weights	**3 X wk**
Bowel movements	
Drive a stick shift	
Eat out frequently	
Enjoy work	
Exercise	
Healthy relationships	
Lift weights	
Nicotine	
Phone work excessive	
Skip meals	
Sleep comfortably	
Sleep on stomach	
Two story residence	
Wear seat belts	
Work hours per week	

Rate Your Activities

Rate the degree of pain related to performing these activities.

	None	Some	Always
Climbing Stairs	☐	☐	☐
Computer work	☐	☐	☐
Dressing	☐	☐	☐
Driving/riding in cars	☐	☐	☐
Exercise	☐	☐	☐
Getting in/out of cars	☐	☐	☐
Getting out of bed	☐	☐	☐
Using the restroom	☐	☐	☐
Housework	☐	☐	☐
Running	☐	☐	☐
Sexual Intercourse	☐	☐	☐
Sitting	☐	☐	☐
Taking care of child	☐	☐	☐
Walking	☐	☐	☐
Yard work	☐	☐	☐

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Our Financial Policy

C4.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. All patients are responsible to check out with the front desk to satisfy any payment due at the time of the service.

1. Patients without Insurance:
All payments are expected at the time of service unless other arrangements are made with YWC. If an arrangement was made the payment for the service will be expected within 15 days of the service. If payment is not received within 15 days the balance due will be charged to the credit card listed on the credit card authorization that is listed at the end of this policy.

2. Patients with Insurance:
Deductibles, co-insurance and all co-payments, along with any services not covered by insurance are expected at the time of service. Unless other arrangement is made to delay this payment until the insurance company pays. Then the client will have 15 days to pay the balance due. If payment is not made in 15 days, the credit card listed on the credit card authorization that is listed at the end of this policy will be charged.

3. Purchase of Supplements, Supplies or Non Insurance Services:
All supplements, supplies and services not covered by insurance must be paid for at the time they are received. There are no exceptions on these items or services.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I and/or my dependents have coverage with the insurance as presented to Your Wellness Connection PA and assign directly to Your Wellness Connection, PA all benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

AUTHORIZATIONS: I hereby acknowledge that I have read the above policy regarding my financial responsibility to Your Wellness Connection PA for medical services and treatment provided and I agree to pay Your Wellness Connection PA any balance unpaid by my insurance carrier or not covered by an insurance carrier for myself and the person named below.

I hereby authorize Your Wellness Connection PA to charge my credit or debit card listed below for the full amount owed by me for all services and/or treatments, or supplements and supplies rendered by Your Wellness Connection PA in accordance with this agreement.

This authorization shall remain in effect unless and until it is revoked by you in writing and delivered to the office of Your Wellness Connection PA at 7410 Switzer Rd, Shawnee, KS 66203.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: I consent to the use or disclosure of my medical information by Your Wellness Connection (YWC) and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of YWC. I understand that diagnosis or treatment of me by YWC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. YWC is not required to agree to the restrictions that I may request. However, if YWC agrees to a restriction that I request, the restriction is binding on YWC. I have the right to revoke this consent, in writing, at any time, except to the extent YWC has taken action in reliance on this consent.

(Continued on next page...)

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Our Financial Policy *(continued...)*

C4.2

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review YWC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of YWC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of YWC. This Notice of Privacy Practices also describes my rights and the duties of YWC with respect to my medical information. YWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: _____ **Date:** _____

Printed Name: _____

Others covered by this agreement: _____

CREDIT CARD INFO

Credit Card # _____ **Card Type:** VISA MASTERCARD DISCOVER AMEX

Expiration Date: _____ **3-digit security code:** _____

Name as it appears on card: _____

Address statement is sent to: _____

_____

Authorization Signature: _____ **Date:** _____

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Chiropractic Informed Consent

C5

Name: _____ **Date of Birth:** _____ **Date:** _____

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, acupuncture, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

Adjustment: Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential current therapy: Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental traction therapy: This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Acupuncture: This ancient Chinese practice using the insertion of needles is used to restore proper energy flow through the body known as Chi, the vital life energy that flows through every living thing.

Exercise: The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program.

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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