Peters Wellness Chiropractic, Inc.

New Patient Application

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Email Address:_____

Birth Date: _____ Age: _____ Sex: M F Social Security #:_____

Your Occupation: ___ Your Employer: _____ Year's Employed: _____

Marital Status: __S __M __W __D Spouse's Name: _____ Spouse's Occupation: _____

Number of children and ages: _____

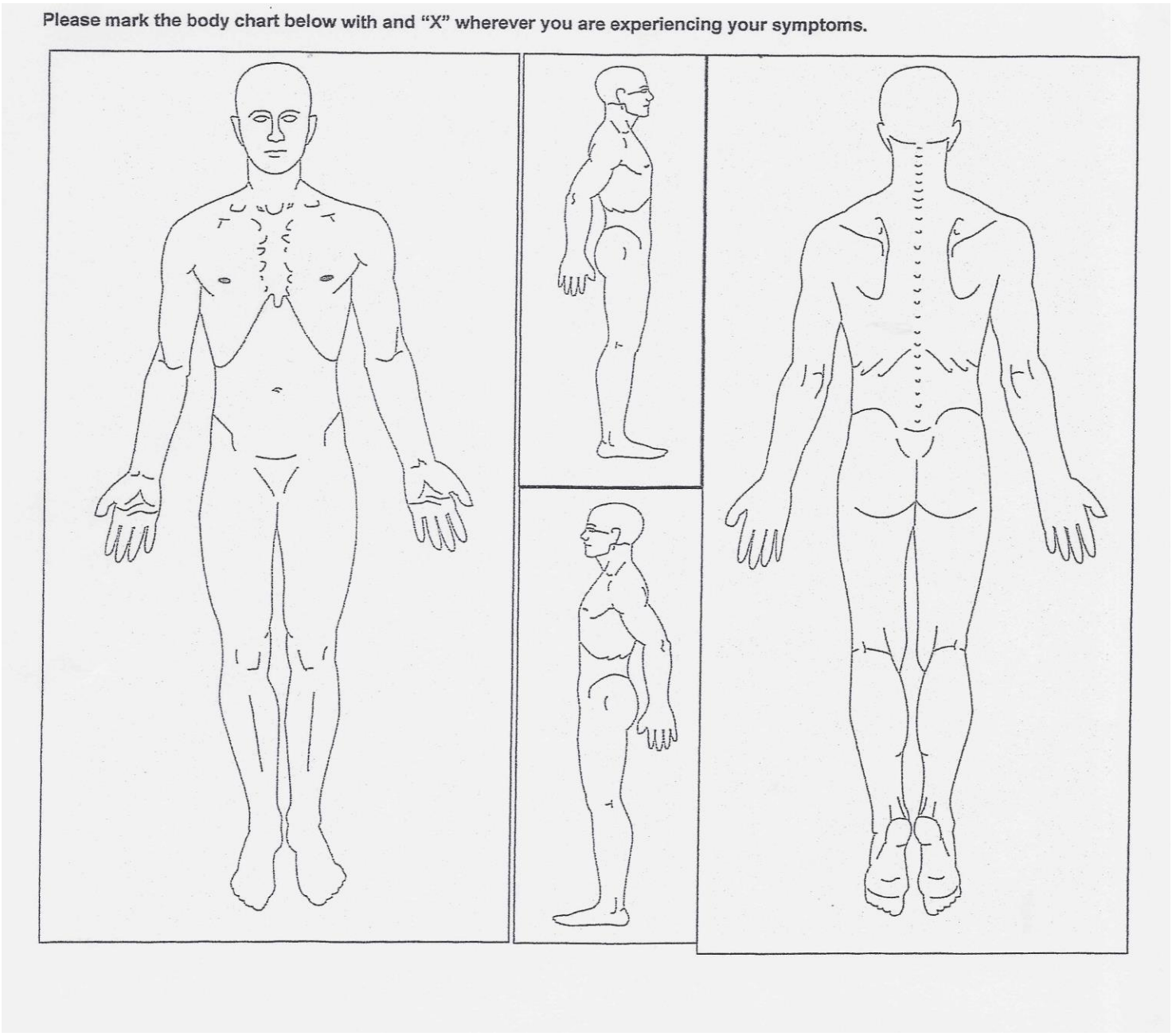
Have you seen a Chiropractor before? Yes No If so, approximate date and name of Doctor:_____

Who may we thank for referring you to us or how did you hear about us: _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Did your injury occur during: Auto Accident Work Related Sports/Play Routine/Household Activity

Please mark the body chart below with and "X" wherever you are experiencing your symptoms.



1616 North Litchfield Road, Suite 100, Goodyear, AZ. 85395 - Phone #: 623-935-0911 – Fax #: 623-935-0921

www.PetersWellness.com

Peters Wellness Chiropractic, Inc.
New Patient Application

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, **_____** being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle.

_____

_____ _____
(signature) (date)

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Notice Of Privacy – HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure Of Your Health Care Purposes
We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment, or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or medical billing clearinghouse or collection agencies for the purpose of payment for your health care services.

Workers' compensation
We may disclose you health information as necessary to comply with state Work Comp Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or on the event of an emergency.

Other
As required by law, we may disclose your health information to the fallowing persons or entities:
-Public Health Authorities, -Law Enforcements Officials, -Medical Examiners or Coroners, -Specialized Government Agencies

Communications
We may contact you for additional communications, or other purpose, as described below:
It is our policy to call your home on the day prior to you scheduled appointment to remind you of your appointment time. A reminder message is left with a person or answering machine if you are not at home. Birthday cards and/or seasonal greeting cards may be sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift, or medical reminders. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy. When you are being seen in the office, other patients may hear and see the care you receive. A private area is available upon request.

Change of Ownership
In the event that this practice is sold or merged with another organization, your health record will become the property of the new owner.

Your health Information Rights
-You have the right to request restrictions on certain uses and disclosers of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
-You have the right to inspect and copy your health information.
-You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If you requested to amend your health information has been denied, you will be provided with a explanation of our denial reason(s) and information about how you can disagree with the denial.
-You have a right to receive an accounting of disclosures of your protected health information made by our office.
-You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

We are required by law to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about our privacy rights, please contact our office manager.

Complaints
Complaints about our Privacy Rights or how our office handles the use or disclosure of your health information should be directed to our office manager. If you are not satisfied with the manager in which this office handles your complaint, you may submit a formal complaint to:
DDHS, Office of Civil Rights, 200 Independence Ave., S.W., Room 509F HHH Building, Washington, DC 20201

I have read the privacy notice and understand my rights contained in the notice.

Printed Name of Patient: _____

Signature of Patient: _____ Date: ____/____/____

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List surgical operations and dates:

1. Date:_____ Type:_____
2. Date:_____ Type:_____
3. Date:_____ Type:_____
4. Date:_____ Type:_____

List any past accidents with dates:

1. Date:_____ Type:_____
2. Date:_____ Type:_____
3. Date:_____ Type:_____
4. Date:_____ Tyep:_____

List any <u>prescription</u> medications you are taking (if you are taking more than 5 please inform the doctor during your exam):

1. Drug Name:_____ Dosage and Frequency:_____
2. Drug Name:_____ Dosage and Frequency:_____
3. Drug Name:_____ Dosage and Frequency:_____
4. Drug Name:_____ Dosage and Frequency:_____
5. Drug Name:_____ Dosage and Frequency:_____

List any <u>non-prescription</u> drugs that you are taking (if you are taking more than 5 please inform the doctor during your exam):

1. Drug Name:_____ Dosage and Frequency:_____
2. Drug Name:_____ Dosage and Frequency:_____
3. Drug Name:_____ Dosage and Frequency:_____
4. Drug Name:_____ Dosage and Frequency:_____
5. Drug Name:_____ Dosage and Frequency:_____

List any dietary supplements or vitamins that you are taking:

1. Name:_____ What is this product for:_____
2. Name:_____ What is this product for:_____
3. Name:_____ What is this product for:_____
4. Name:_____ What is this product for:_____
5. Name:_____ What is this product for:_____

Family Health History:

Grand Parents:_____

Parents:_____

Brothers/Sisters:_____

_____

Immediate Family Deaths: _____

Other health information:

Do you exercise? Yes No If yes, # of hours per week: _____

Do you wear: Arch Supports/Orthotics? Yes No If yes, how many arches do they support in each foot? 1 2 3

Are you dieting? Yes No If so, since when: _____

Are you taking birth control? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Smoking Status: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked Age You Started Smoking?_____

Height:_____ Weight_____ Blood Pressure:_____/_____ (We can perform here in office)

All of the above is accurate to the best of my knowledge (please sign): _____ Date: _____

I, parent/guardian, give permission for minor's care (please sign): _____ Date: _____

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Have you had any of the following diseases, medical conditions or procedures?

If yes, then O=Onset (month/year), B/W= What makes it better or worse, S=Severity (1-10 with 10 being the worst) & T=Timing 0-100% of waking hrs.

Y N Alcohol Use: How many Times/Month:_____

Y N Allergies: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Anemia: O:_____

Y N Artificial Implants: When:_____ What:_____

Y N Artificial Joints: When:_____ What:_____

Y N Arteriosclerosis: As of when:_____

Y N Arthritis: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Asthma: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Cancer: Type:_____

Y N Chemo Therapy: When:_____

Y N Constipation: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Depression: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Diabetes Type I: O:_____

Y N Diabetes Type II: O:_____

Y N Diarrhea: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Digestive Issues: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Dizziness: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Epilepsy: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Fainting: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Fatigue: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Glaucoma: O:_____

Y N Heart Attack(s): Date(s)_____

Y N Heartburn/Gastric Reflux: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Heart Murmur: O:_____

Y N Hepatitis: O:_____ Type:_____

Y N High/Low Blood Pressure: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Hot Flashes: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Irritability: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Kidney Problems: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Light Sensitivity: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Menstrual Cramping: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Mood Swings: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Multiple Sclerosis: O:_____ B/W:_____
S (1-10):_____

Y N Pace Maker: When:_____

Y N Periods Irregular: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Pleurisy: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Pneumonia: When:_____

Y N Polio: O:_____

Y N Psychiatric Problems: O:_____ B/W:_____
S (1-10):_____

Y N Rheumatic Fever: O:_____

Y N Ringing in Ears: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Shingles: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Sinus Problems: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Stomach Issues: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Stroke(s): When:_____

Y N Thyroid Issues: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____%

Y N Tuberculosis:

Y N Ulcers: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Urinary Issues: O:_____ B/W:_____
S (1-10):_____ T (0-100% waking hours):_____

Y N Venereal Disease: O:_____ Which one:_____

Name:_____ **Date:**_____

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We believe in working closely with other health care providers, please provide your Primary Care Physician's information:
Name of Doctor: _____
Office Name: _____
Office Address: _____
Date of Last Visit: _____ Purpose of Last Visit: _____

Have you seen your Primary Care Physician for any of the above mentioned issues? Yes No **If Yes, when:**_____

Have you seen other doctor's for the above condition(s)? If yes please fill in information below:
Doctor: _____ Diagnosis: _____ X-rays: _____
Treatment: __Medication, __Physiotherapy, __Other: _____
Results: _____ Length of time under care: _____

In compliance with the government EHR program, please answer the following questions

E-Mail Address:_____
Preferred method of contact: (Circle One) Email / Phone / Mail

Text Message & Email Notification

How would you like to be notified? (Please Circle One) -Text Message -Email

If you circled text message, who is your service provider and cell phone number?

Provider:_____ Cell Number:_____

For both text and email:
How long in advance would you like your appointment reminder? (Please Circle One)

15 min 30 min 1 hour 2 hours 4 hours 1 day 2 days

Preferred Language: _____

CMS (Medicare) requires providers to report both Race & Ethnicity

Race: (Circle One) American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline To Answer
Ethnicity: (Circle One) Hispanic or Latino / Non Hispanic or Latino / I Decline To Answer

Do you have any medication allergies?

Allergy 1:_____ Reaction _____ Onset Date_____

Allergy 2:_____ Reaction_____ Onset Date_____

Allergy 3:_____ Reaction_____ Onset Date_____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Peters Wellness Chiropractic, Inc.
New Patient Application

Mark 1 area only

1. Location of 1st Problem/Pain/Issue:
L=Left, R=Right, B=Both

__ Headaches L R B
__Front of Head
__Top and/or Sides
__Back of Head
__Jaw L R B
__Eye L R B
__Neck L R B
__Mid Back L R B
__Low Back L R B
__Chest L R B
__Abdomen L R B
__Ribs L R B
__Buttocks L R B
__Shoulder L R B
__Upper Arm L R B
__Forearm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B
__ Other (describe):
_____
_____

2. Quality of Pain: Depending upon which fibers of a nerve are pinched, subluxations can result in different feelings. How would you describe your pain?
__Dull __Sharp __Aching __Cramping __Pounding __Cutting __Throbbing __Burning __Spasms
__Numbing __Tingling __Stinging __Shooting __Stabbing __Cool __Warm __Constricting

3. Pain Frequency - During waking hours
__Up to 1/4 of awake time __ 1/4 to 1/2
__1/2 to 3/4 of awake time __Most of time

4. Pain Intensity - With daily activities
__Doesn't affect __Somewhat affects
__Seriously affects __Prevents activities

5. Does this Pain Radiate? The more severe the nerves are pinched, the further from the source of the problem the pain can radiate. Does the pain sometimes or constantly travel to any of these area?
__Head L R B
__Neck L R B
__Shoulder L R B
__Arm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B

6. Actions Affecting this Pain (circle an A or R below)

	A=Aggravates,	R=Relieves
Upon waking	A	R
Before bed	A	R
Bending Forward	A	R
Bending Back	A	R
Bending Left	A	R
Bending Right	A	R
Twisting Left	A	R
Twisting Right	A	R
Coughing	A	R
Sneezing	A	R
Straining	A	R
Standing	A	R
Sitting	A	R
Lifting	A	R
Other Actions (describe):		
_____	A	R
_____	A	R
_____	A	R
_____	A	R

7. When did this pain begin? Be as specific as you can: Month:_____ Day:_____ Year:_____

8. Is this the first time you have had this type of pain in this area of the body? Yes No
If No, please indicate when you have had this type of pain in the past: Month:_____ Day:_____ Year:_____

9. On a scale of 1 to 10 (10 being the worst pain you have ever had) how would you rate the pain today? 1 2 3 4 5 6 7 8 9 10

10. On a scale of 1 to 10 how would you have rated the pain when it started? 1 2 3 4 5 6 7 8 9 10

11. What action or activity do you think caused this pain to begin?_____
_____
_____
_____
_____

12. Is there anything else about this complaint you feel is important?_____
_____
_____
_____
_____

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Mark 1 area only

1. Location of 2nd Problem/Pain/Issue:
L=Left, R=Right, B=Both

__ Headaches L R B
__Front of Head
__Top and/or Sides
__Back of Head
__Jaw L R B
__Eye L R B
__Neck L R B
__Mid Back L R B
__Low Back L R B
__Chest L R B
__Abdomen L R B
__Ribs L R B
__Buttocks L R B
__Shoulder L R B
__Upper Arm L R B
__Forearm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B
__ Other (describe):
_____
_____

2. Quality of Pain: Depending upon which fibers of a nerve are pinched, subluxations can result in different feelings. How would you describe your pain?
__Dull __Sharp __Aching __Cramping __Pounding __Cutting __Throbbing __Burning __Spasms
__Numbing __Tingling __Stinging __Shooting __Stabbing __Cool __Warm __Constricting

3. Pain Frequency - During waking hours
__Up to 1/4 of awake time __ 1/4 to 1/2
__1/2 to 3/4 of awake time __Most of time
_____

4. Pain Intensity - With daily activities
__Doesn't affect __Somewhat affects
__Seriously affects __Prevents activities

5. Does this Pain Radiate? The more severe the nerves are pinched, the further from the source of the problem the pain can radiate. Does the pain sometimes or constantly travel to any of these area?
__Head L R B
__Neck L R B
__Shoulder L R B
__Arm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B

6. Actions Affecting this Pain (circle an A or R below)

	A=Aggravates,	R=Relieves
Upon waking	A	R
Before bed	A	R
Bending Forward	A	R
Bending Back	A	R
Bending Left	A	R
Bending Right	A	R
Twisting Left	A	R
Twisting Right	A	R
Coughing	A	R
Sneezing	A	R
Straining	A	R
Standing	A	R
Sitting	A	R
Lifting	A	R
Other Actions (describe):		
_____	A	R
_____	A	R
_____	A	R
_____	A	R

7. When did this pain begin? Be as specific as you can: Month:_____ Day:_____ Year:_____

8. Is this the first time you have had this type of pain in this area of the body? Yes No
If No, please indicate when you have had this type of pain in the past: Month:_____ Day:_____ Year:_____

9. On a scale of 1 to 10 (10 being the worst pain you have ever had) how would you rate the pain today? 1 2 3 4 5 6 7 8 9 10

10. On a scale of 1 to 10 how would you have rated the pain when it started? 1 2 3 4 5 6 7 8 9 10

11. What action or activity do you think caused this pain to begin?_____
_____
_____
_____
_____

12. Is there anything else about this complaint you feel is important?_____
_____
_____
_____
_____

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Mark 1 area only

1. Location of 3rd Problem/Pain/Issue:
L=Left, R=Right, B=Both

__ Headaches L R B
__Front of Head
__Top and/or Sides
__Back of Head
__Jaw L R B
__Eye L R B
__Neck L R B
__Mid Back L R B
__Low Back L R B
__Chest L R B
__Abdomen L R B
__Ribs L R B
__Buttocks L R B
__Shoulder L R B
__Upper Arm L R B
__Forearm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B
__ Other (describe):
_____
_____

2. Quality of Pain: Depending upon which fibers of a nerve are pinched, subluxations can result in different feelings. How would you describe your pain?

__Dull __Sharp __Aching __Cramping __Pounding __Cutting __Throbbing __Burning __Spasms
__Numbing __Tingling __Stinging __Shooting __Stabbing __Cool __Warm __Constricting

3. Pain Frequency - During waking hours

__Up to 1/4 of awake time __ 1/4 to 1/2
__1/2 to 3/4 of awake time __Most of time

_____

4. Pain Intensity - With daily activities

__Doesn't affect __Somewhat affects
__Seriously affects __Prevents activities

5. Does this Pain Radiate? The more severe the nerves are pinched, the further from the source of the problem the pain can radiate. Does the pain sometimes or constantly travel to any of these area?

__Head L R B
__Neck L R B
__Shoulder L R B
__Arm L R B
__Hand L R B
__Hip L R B
__Leg L R B
__Foot L R B

6. Actions Affecting this Pain (circle an A or R below)

	A=Aggravates,	R=Relieves
Upon waking	A	R
Before bed	A	R
Bending Forward	A	R
Bending Back	A	R
Bending Left	A	R
Bending Right	A	R
Twisting Left	A	R
Twisting Right	A	R
Coughing	A	R
Sneezing	A	R
Straining	A	R
Standing	A	R
Sitting	A	R
Lifting	A	R
Other Actions (describe):		
_____	A	R
_____	A	R
_____	A	R
_____	A	R

7. When did this pain begin? Be as specific as you can: Month:_____ Day:_____ Year:_____

8. Is this the first time you have had this type of pain in this area of the body? Yes No
If No, please indicate when you have had this type of pain in the past: Month:_____ Day:_____ Year:_____

9. On a scale of 1 to 10 (10 being the worst pain you have ever had) how would you rate the pain today? 1 2 3 4 5 6 7 8 9 10

10. On a scale of 1 to 10 how would you have rated the pain when it started? 1 2 3 4 5 6 7 8 9 10

11. What action or activity do you think caused this pain to begin?_____
_____
_____
_____
_____

12. Is there anything else about this complaint you feel is important?_____
_____
_____
_____
_____

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