WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Name _____ Sex M /F Date_____
Address _____City_____ State_____ Zip_____
Home Phone _____Cell Phone_____ Date of Birth _____ Age_____
How did you hear about us _____ Email address_____
Have you ever received Chiropractic Care? Yes__ No__ If yes, when? _____
Would you like to pay with: Insurance (please give front desk your card) OR out of pocket (Circle one).
Is this an Auto Accident or Work Comp related injury? (circle): Insurance/claim #: _____
Date of Accident or injury: _____

1. Reasons for seeking chiropractic care:

Primary concern: _____
Secondary concern: _____
Other concern: _____

2. Your current Pain experience

Where is the pain today? _____
When did this recent concern begin? _____
How did your pain begin?
___Singular event or trauma. ___This has happened several times before? YES/NO. Number of episodes:_____
___Slowly began after a certain activity. ___No reason why this occurred.
Circle how often does this bother you?
Daily Weekly Monthly Other_____
How long does it last?
Seconds Minutes Hours Other_____
Please circle the Quality of the complaint/pain:
dull aching sharp shooting burning throbbing deep nagging Other_____
Grade Intensity/Severity (0 No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain imaginable)
What makes the pain worse?
_____
What makes the pain better?
_____
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where?
_____
Do you have any additional Symptoms outside of the pain:
❑ Numbness ❑ Muscle Weakness ❑ Pins/Needles/Tingling ❑ Difficulty with urination ❑ Difficulty Breathing ❑ Chest Pain ❑ Dizziness ❑ Tension ❑ Excessive sweating ❑ Fever ❑ Fatigue ❑ Sickness ❑ Weight Loss/gain ❑ Bruising ❑ Bleeding ❑ Painful/Swollen Joints ❑ Headache ❑ Nausea ❑ Vomiting ❑ Changes in Vision ❑ Sensitivity to Light/Sound ❑ Cough ❑ Rash ❑ Difficulty Sleeping
Where? _____
Does this complaint interfere with: work, home life, activities or sleep? Y/N
_____
Are you presently under a doctor's care for this complaint? Y/N Doctors/Clinic name:
_____
Are you currently pregnant or is there any possibility that you might be pregnant? Yes, No, Not Sure (circle one)

Are there any other health concerns you would like to discuss? _____

3. Previous interventions: treatments, medications, surgery, or care you've sought for this pain:

_____

4. Past Health History:

A. Previous illnesses/conditions you've had in your life:
(Gender assignment at birth may impact investigation of current health issues)
❑ Diabetes ❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Ulcers ❑ AIDS/HIV ❑ Joint Replacement ❑ Glaucoma
❑ Hepatitis ❑ Anemia ❑ Alcoholism ❑ Lung Disease ❑ Heart Disease ❑ Diverticulitis ❑ Pacemaker ❑ Kidney Disease
❑ Thyroid Disease ❑ Tuberculosis ❑ Hypertension ❑ Blood Thinners ❑ Depression ❑ Anxiety
❑ Other_____

B. Surgeries/Hospitalizations/Injuries/Fractures/Dislocations: (Please provide Month/Year)

_____
C. Allergies _____
D. Current Medications/Supplements: _____
E. Conditions you are taking medications for: _____

5. Family Health History:

Health problems of your family:(please label parents, siblings, children):
Family Medical History (Please check all that apply)
□ N/A, I do not know my family history
❑ Diabetes ❑ Cancer ❑ Rheumatoid Arthritis ❑ Osteoarthritis ❑ Scoliosis ❑ Muscular Disease
❑ Hypertension ❑ Heart Disease
❑ Stroke ❑ Other_____

6. Social and Occupational History:

Lifestyle Habits: Do you exercise weekly? Yes/No Form of exercise _____ Times /wk _____
Caffeinated Beverages: Yes/No If yes, #/day?_____
Tobacco: Yes/No If yes, frequency?:_____ How long have you used tobacco? _____
Alcoholic Beverages: Yes/No If yes, #/day?_____
Cannabis/Marijuana: Yes/No If yes, preferred method of intake_____
Other Substances: cocaine/opiates/psilocybin/other:_____
Occupation (place of work): _____ What you do: _____

Other information we should know about:

_____
_____

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Informed Consent For Chiropractic

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Analysis / Examination / Treatment As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation and soft tissue massage, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, and radiographic studies.

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including **stroke**. Some patients may feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options: Other treatment options for your condition may include: Self-administered, over-the-counter analgesics, rest, medical care, prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization, or surgery.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. 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 the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Patient's Name Parent's Name (If Minor)

_____

Signature of Patient or Guardian (if a minor) Dated: _____

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Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

Name(s): _____

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

- ☐ Check box if you want to **OPT OUT** of voicemails.
- ☐ Check box if you want to **OPT OUT** of text message reminders.
- ☐ Check box if you want to **OPT OUT** of Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you discount on your treatments here. You can use the TOSD for any service offered here. Pricing is dependent on the services performed. Please ask the front desk for specific pricing. **In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.**

_____ _____

Patient Name Date

_____ _____

Patient Signature (Parent Signature if minor) Parent Name (If Minor)

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____ _____

Patient name Date

_____

Signature Patient/Guardian