Welcome

ABOUT YOU	Name:_____ DOB :_____/_____/_____ Sex: □ M □ F Street Address:_____ City:_____ State:_____ Zip:_____ Phone:_____ Other #: _____ Email: _____ Employer: _____ Occupation: _____ Employer's Address:_____ City:_____ State:____ Zip:_____ Status: □ Single □ Married □ Divorced □ Separated □ Widow S.S.#: _____/_____/_____ Race: (Circle One) American Indian / Asian / African American / Caucasian / Pacific Islander Ethnicity: Hispanic / Not Hispanic / I Decline to Answer Preferred Language: _____ Smoking Status (Circle one): Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoker Emergency Contact Name : _____ Relationship: _____ Phone #: (_____) _____
REASON FOR YOUR VISIT	Reason For Your Visit:_____ Have You Ever Been Treated By A Chiropractor Before? □ Yes □ No For:_____ When Did Symptoms Start: Is It Getting Worse? □ Yes □ No
HEALTH INFORMATION	Please List, And Give Dates Of Any Surgeries **You** Have Had: _____ _____ __ Pregnant? □ Yes □ No IF YES, how many weeks: _____ Allergies to any meds: □ Yes □ No IF YES what meds_____ List all prescribed medications: _____ _____ _____ _____
PATIENT AGREEMENT	**ASSIGNMENT AND RELEASE** I, The undersigned, have insurance coverage with _____ and assign directly to Dr. Wells all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ _____ **Signature of Insured/Guardian** **Date**

WELLS CHIRO HEALTHCARE

MEDICAL HISTORY

Personal History — Check All That Apply

General Questions	Cardiovascular	Kidneys & Urinary Tract	Musculosketal
□Weight Loss/Gain	□Angina	□Blood In The Urine	□Gout
□Change in Sleep Patterns	□Leg Cramps	□Painful Urination	□Abnormal Blood Counts
□Change in activity capacity	□Ankle Swelling	□Incontinence	□Blood Clots in Legs/Lungs
Neurological & Psychiatric	□Awakening Short of Breath	□Urinating frequently	□Bone Marrow Biopsy
□Anxiety	□Cardiac Catherization	□Frequent Bladder Infections	□Easy Bleeding or Bruising
□Headaches	□Congenital Heart Defects	□Kidney Disease	□Joint Swelling/Pain
□Depression	□Heart Attacks or Failure	□Kidney Stones	□Muscle Aches
□Meningitis	□High or Low Blood Pressure	**Respiratory**	□Arthritis
□Paralysis	□Irregular Heart Rate	□Pleurisy	□Bursitis
□Seizure	□Purple Fingers or Lips	□Asthma	□Tendonitis
□Stroke	□Heart Palpitations	□Prolonged Coughing	**Gastrointestinal**
□Tingling	□Varicose Veins	□Coughing Up Blood	□Reflux/Heartburn
□Tremors	**Endocrine**	□Emphysema	□Hepatitis
□Memory Loss	□Diabetes	□Tuberculosis	□Vomiting Blood
□Fainting Spells/Dizziness	□Cold/Heat Intolerance	□Shortness Of Breath	□Problems Swallowing
□Head Injuries	□Thyroid Disease	□Frequent Bronchitis	□Hiatal Hernia
□Localized weakness/numbness	□Sickle Cell		□Liver Disease
	□Hormone Replacement		□Indigestion

Family History — Check All That Apply

Medical Condition	Diagnosis Code	Father	Mother	Sister	Brother	Daughter	Son
Alzheimer	G30.9						
Asthma	J45.90						
Chronic Congestive Heart Failure	I50.22						
Chronic Kidney Disease	N18.9						
Gout	M10						
Hypertension	I15.0						
Migraine	G43.9						
Osteoarthritis	M19.90						
Osteoporosis	Z82.62						
Scoliosis, unspecified	M41.9						
Stroke	I63.9						

WELLS CHIRO HEALTHCARE
INFORMED CONSENT

To set clear expectations, improve communications please read each section and initial your agreement.

_____ I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physician or staff at Wells Chiro Healthcare. I understand, and am informed that, while extremely rare, there are some risks to treatment including but not limited to: fractures, disc injuries, dislocations, sprains, strains and stroke. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts known it is in my best interest. I have read, or have had read to me, the above consent. I will have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or staff. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

_____ I also hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic ` x-rays by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of knowledge I am not pregnant. Date of the last menstrual period (mm/dd/yyyy): _____ **(Women Only).**

_____ I grant, this office, permission to be contacted to confirm or reschedule an appointment.

My preferred method for appointment reminders is :

Email: _____ Phone Call: _____

Text: _____ Cell phone carrier: _____

_____ **X**_____ _____

Print Patient's Name | Patient/Guardian Signature | Date

_____ _____ _____

Print Witness Name | Witness Signature | Date

WELLS CHIRO HEALTHCARE

Notice of Privacy Practice – Acknowledgment & Consent

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by WELLS CHIRO HEALTHCARE or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operation of this office.

Notice of Privacy Practice

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your right as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____	**X**_____	_____
Print Patient's Name	Patient/Guardian Signature	Date

_____	_____	_____
Print Witness Name	Witness Signature	Date