

Please fill out this form, in its entirety, in blue or black ink

Date: _____

Patient Information:

Patient Full Name: _____ Preferred to be called: _____

Parent/Guardian(s) Name: _____

Address: _____ City, State, Zip Code: _____

Date of Birth: ____/____/____ Age: _____ SSN: _____ Gender at Birth: _____

Primary Contact _____ Relationship: _____ Contact # _____

Secondary Contact _____ Relationship: _____ Contact # _____

E-Mail Address (we will not give out to others): _____

Who may we thank for referring you to our office? _____

What Conditions are you seeking treatment for? (i.e. lower back pain, neck pain, headaches, etc.)

Describe Condition #1: _____

How did this condition develop? _____

Date of Onset: _____ Have you gotten other tests or treatment for this condition: If yes, please explain:

- This condition is...(CIRCLE all that apply):

Sharp Shooting Aching Throbbing Burning Numbness Weak
Constant Frequent Comes & Goes Getting Worse

- What is your level of discomfort on a scale of 0-10? (0=No Pain, 10=Severe Pain) ____/10
- Is it interfering with circle all that apply... School Sleep Daily Routine Sports/Hobbies Development
- What does it keep you from doing? _____
- What makes this condition better? _____
- What makes it worse? _____

Describe Condition #2: _____

How did this condition develop? _____

Date of Onset: _____ Have you gotten other tests or treatment for this condition: If yes, please explain:

- This condition is...(CIRCLE all that apply):

Sharp Shooting Aching Throbbing Burning Numbness Weak
Constant Frequent Comes & Goes Getting Worse

- What is your level of discomfort on a scale of 0-10? (0=No Pain, 10=Severe Pain) ____/10
- Is it interfering with circle all that apply... School Sleep Daily Routine Sports/Hobbies Development
- What does it keep you from doing? _____
- What makes this condition better? _____
- What makes it worse? _____

Health History: If NONE, write in NONE otherwise please explain/list

Allergies/Food Allergies: _____

Accidents/Injuries: _____

Surgeries/Hospitalizations: _____

Current Medications/ Supplements: _____

Other medical conditions/diagnosis/symptoms: _____

Vaccines? ☐ On Schedule ☐ Delayed Schedule ☐ Do Not Vaccinate

Medical Doctor's Name: _____ Previous Chiropractor: _____

Growth and Development: If NONE, write in NONE otherwise please explain/list

Did your child have any delays with crawling, walking, speech, or other functions:

Did your child have any academic delays or problems with concentration at school:

Current Sports/Activities/Job:

How many hours a day does your child engage in technology? (Tablets, Phones, TV, Etc.) _____

Females:

Has your child started their menstrual cycle (Y/N) If yes what age? _____ Regular or Irregular: _____

Taking birth control? (Y/N) _____ If yes, what kind? _____

Previous or Presently Pregnant? (Y/N) _____ If yes, when? _____

Payment Information:

☐ I currently have BCBS or Medicare. I give full authorization to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I do know that I am ultimately responsible for any balance on my account.

*CWC will need a copy of your insurance card and all of the insured's information in order to bill today.

☐ I have other insurance and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.

☐ I have a worker's compensation, automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account.

☐ I do not have insurance benefits and will be paying as a cash patient. I am fully responsible for my account.

Responsible Party (if other than patient or if patient is a minor) _____

Consent to Examination and Treatment

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and/or any other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection to perform any examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to myself or minor child.

Parent/Guardian Signature: _____

Date: _____

Review of Systems

Name: _____

Date: _____

At Chiropractic Wellness Connection, we strive to find the CAUSE of your concerns. This questionnaire will help us to identify what is going on specifically for you. Please rate each of the following symptoms based what you have experienced in the **last 60 days**.

Point Scale: leave blank = *never* have the symptom, 1 = *occasionally* have symptom,
2 = *regularly* have symptom, 3 = *frequently* have symptom, 4 = *constantly* have symptom

Eyes, Ears, Nose, Throat:

- ☐ chronic ear infections
- ☐ ringing in the ears
- ☐ blurred or tunnel vision
- ☐ eye pain
- ☐ itchy or watery eyes
- ☐ nasal congestion
- ☐ nose bleeds
- ☐ loss of smell
- ☐ sore throat
- ☐ sores in mouth
- ☐ difficulty swallowing/gagging
- ☐ white patches on throat/tongue
- ☐ need to repetitively clear throat

Musculoskeletal:

- ☐ joint pain
- ☐ joint stiffness
- ☐ pain in muscles
- ☐ abnormal muscle movements
- ☐ muscle weakness

General:

- ☐ unexplained weight loss
- ☐ unexplained weight gain
- ☐ severe fatigue
- ☐ fever
- ☐ excessive thirst
- ☐ frequent illnesses
- ☐ difficulty sleeping

Urinary:

- ☐ difficulty urinating
- ☐ blood in urine
- ☐ chronic UTIs
- ☐ frequent urination

Neurological:

- ☐ tremors/tics
- ☐ difficulty walking
- ☐ difficulty with balance
- ☐ headaches
- ☐ numbness or tingling
- ☐ bruises easily
- ☐ seizures

Digestive:

- ☐ nausea or vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ bloated belly
- ☐ heart burn
- ☐ abdominal pain
- ☐ blood in stool

Mental/Emotional:

- ☐ memory loss
- ☐ depression
- ☐ anxiety/social anxiety
- ☐ confusion
- ☐ inability to focus
- ☐ hyperactivity
- ☐ loss of interest/motivation
- ☐ homicidal/suicidal thoughts

Respiratory:

- ☐ short of breath
- ☐ wheezing
- ☐ asthma
- ☐ coughing

Integumentary:

- ☐ itchy skin
- ☐ rashes
- ☐ jaundice
- ☐ swollen lymph nodes
- ☐ hair loss

Cardiovascular:

- ☐ chest pain
- ☐ heart palpitations
- ☐ irregular heartbeat
- ☐ fainting
- ☐ swelling in hands/feet
- ☐ difficulty with speech
- ☐ dizziness
- ☐ restless legs
- ☐ slurred speech

Female Reproductive Only:

- ☐ abnormal periods
- ☐ excessive bleeding/clots
- ☐ period irregularity
- ☐ loss of pregnancy
- ☐ slurred speech

Total: _____

Brookside Radiology Consultants, Inc.

P.O. Box 349

Buzzards Bay, MA 02532

Phone: 508-743-5691

Fax: 774-302-4713

X-Ray Assignment Agreement and Consent

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

Patient Name (Please Print Clearly) Patient Signature

Today's Date: _____

Birth Date: _____ Age: _____ Sex: M F

To be completed by office staff:

Referring Doctor: _____ Clinic Phone: _____ Date of Films: _____

X-Ray Studies Submitted: _____ Clinical Concern: _____

Comments: _____

Chiropractic Wellness Connection
410 E. Elm St.
Canton, IL 61520

Consent to Examination and Treatment of Minor

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection under their supervision, to perform examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to my minor child:

Name of minor: _____

Further, I state and agree that in no manner or form have I been promised a cure of any conditions or diseases. I understand that my child's care may involve the making of judgments based on the facts known to the doctor at this time. I authorize the doctor to exercise judgment during the course of any procedure which he/she feels at the time would be in my child's best interests based on known facts.

I hereby affirm that I have the legal right to select and authorize health care services for the minor child named above. If for any reason, my status of authorization changes, I will notify this office immediately.

I have read and agree to all of the above statements and give consent to examination and treatment of said minor.

_____	_____
Date	Printed Name of Guardian
_____	_____
Relationship to patient	Signature of Guardian

PAYMENT INFORMATION

- I currently have BCBS. I give full permission to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I do know that I am ultimately responsible for any balance on my account.
*CWC will need a copy of your insurance card and all of the insured's information in order to bill today.
- I have other insurance and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.
- I have an automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account.
- I do not have insurance benefits and will be paying as a cash patient. I am fully responsible for my account. Responsible party (if other than patient or if patient is a minor _____).

I hereby authorize the staff to perform any necessary services needed for proper diagnosis and treatment procedures. I further acknowledge this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes.

Guardian Signature: _____ Date: _____

Communication Regarding Confidential Information

In order for us to keep communication regarding your information confidential, we need the following:

Mark below the means by which you authorize us to contact you. MARK ALL THAT APPLY. Write N/A if you do not want that form of communication.

- ☐ Call Home at this phone number: _____
- ☐ Call Cell at this phone number: _____
- ☐ Text Cell at this phone number: _____
- ☐ Email address: _____

Do you want appointment reminders sent to you? Yes _____ No _____
If yes, how would you like your reminder? Text to Cell phone _____ E-mail _____

May we leave a message and/or talk with another party on your behalf? Yes _____ No _____
Please list authorized person(s) to receive protected health information on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list any other special requests regarding your health information: _____

I, the undersigned, hereby acknowledge that by signing this Consent:

1. I am aware that the Practice's Privacy Notice is available to me upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Privacy Notice is also available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. The Practice's "Notice of Privacy Practices" is provided at 410 E. Elm St., Canton, IL 61520. I may also request a copy from this office at any time directly from the office or via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

Patient's Name (please print): _____

Signature: _____ Date: _____

If you are not the patient, please specify your name and relationship to the patient:

Informed Consent to Care

You are the decision maker for your health care. "Informed consent" involves your understanding and agreement regarding the care we recommend, risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

CHIROPRACTIC TREATMENT involves the management of conditions by means of a chiropractic adjustment, a specific type of joint manipulation performed by hand or instrument with person to person contact. The chiropractic adjustment carries a plethora of benefits but also has risks associated with it. Results are not guaranteed.

Serious risks and side effects associated with the chiropractic adjustment are extremely rare but include the following:

Temporary soreness, muscle spasm, increased pain, dizziness, headache, nausea and increased other symptoms: It is not uncommon for the patients to experience temporary soreness, muscle spasm, headache or increased symptoms or pain after treatments especially with beginning care. It is less likely to experience dizziness and nausea post treatment.

Fractures: When patients have underlying conditions and/or treatments that weaken bones, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening condition and/or medical treatment. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: There is an extremely rare association with stroke and certain types of chiropractic care. This is a very debatable topic as any stroke can occur from a multitude of reasons and the timing can be spontaneous and unknown until the event has occurred no matter the cause. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Patients who are experiencing a stroke may or may not have initial symptoms. We do our best to determine the possibility and risk of stroke with every patient at every visit. There may be times when chiropractic treatment is not given and medical testing is advised instead.

Other possible risks: Other possible risks include but are not limited to bruising, disruptions of internal medical devices, dislocations, and/or sprains and strains. If any of these conditions or symptoms occur, notify your chiropractor immediately.

It is important to know that it is not possible to know every potential complication to care. It is important to notify the chiropractor immediately if you experience these symptoms or any adverse symptoms during or after your care. Your chiropractor has the right to refuse treatment in the event that they have concern with your current condition and do not advise treatment accordingly.

ACUPUNCTURE treatment is a form of therapy in which fine needles are inserted into specific points on the body. Acupuncture is generally very safe and serious side effects are very rare. Acupuncture may be contraindicated on certain patients so notify chiropractor before treatment if you have any of the following: are pregnant, have a pacemaker or other electrical implant, bleeding disorder, blood borne pathogens, or are taking anticoagulants or any other medications. It is important to not move during the insertion, retention, or removal of the needles.

The following are known risks with **acupuncture care**:

Drowsiness and dizziness may occur after treatment in a small number of patients, and, if affected, you are advised not to drive.

Minor bleeding, bruising, pain , temporary worsening of symptoms, numbness and tingling, and/or muscle contractions may occur after treatment.

Infection is another possible risk, although the chiropractor uses sterile, single use, disposable needles.

It is important to know that it is not possible to consider every possible complication to any type of care.

It is also important that you understand there are treatment options available for your condition other than chiropractic and acupuncture procedures. These options may include, but are not limited to: self-administered care, over the counter pain relievers, rest, medical treatment, physical therapy, bracing, injections, and surgery. You have the right to a second opinion and trying other options in healthcare as you see fit.

I have read, or had read to me, the above consent. I have discussed any questions or concerns with my chiropractor and/or their staff , have had these answered to my satisfaction prior to my signing this document and acknowledge that no guarantee can be given as to the results or outcome of my care. I have made my decision voluntarily and freely. I hereby give my consent to the performance of diagnostic tests, procedures and chiropractic treatment, acupuncture treatment and physical modalities recommended by my chiropractor and/or management of my conditions.

Patient Name:

Signature:

_____ Date: _____

Parent or Guardian:

Signature:

_____ Date: _____

Witness Name:

Signature:

_____ Date: _____