CHAMBUL WELLNESS CENTER

NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your Driver's License and Medicare card (if applicable).

PLEASE PRINT CLEARLY

Full Name: _____ Gender: ❑ M ❑ F Age:_____ Birth Date: _____

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

Social Security#: _____-_____-_____ E-Mail: _____ Home Phone: (_____) _____

Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children _____ Work Status: ❑ Full Time ❑ Part Time ❑ Retired Cell: (_____) _____

Females: Last Menstrual Period: _____ Pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Fax: (_____) _____

Employer: _____ Occupation: _____ Work Phone: (_____) _____

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

Name of Spouse, Parent or Guardian: _____ Age: _____ Birth Date: _____ SS#: _____-_____-_____

Spouse's Employer: _____ Spouse's Occupation: _____ Work Phone: (_____) _____

In case of an Emergency Contact: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Do you have **Medicare** insurance? ❑ Y ❑ N

❑ Medicare card copied by Office Staff
❑ Drivers license copied by Office Staff

Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chambul Wellness Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for care given prior to the written request consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Chambul Wellness Center to assure that your records not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

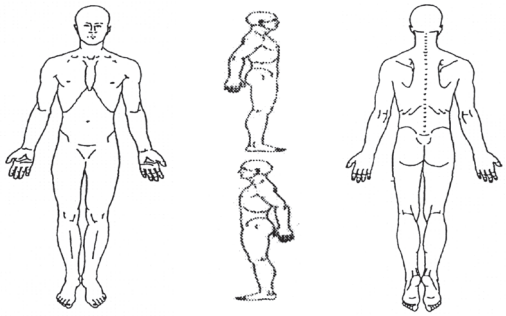
1) _____
2) _____
3) _____
4) _____

TREATMENT: What type of treatment are you looking for?

❑ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
❑ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
❑ I am looking to take care of my problem and then go on to "achieve optimal health and wellness".

Please mark on the diagram to the right the following symbols as they relate to the patients symptoms:

SS=spasms	ST = stiffness
DP=dull pain	SP = sharp pain
SH=shooting pain	TI = tingling
NU=numbness	O = Other



COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor (s) treated you for this condition ❑ Y ❑ N

Whom? ❑ MC ❑ DO ❑ DC ❑ DDS ❑ Other: _____ Name of primary doctor? _____

Treatment(s) Tried: ❑ Medication ❑ Surgery ❑ Lifestyle change ❑ Chiropractic ❑ other _____

Have you had any intolerance or reactions to treatments? ❑ Y ❑ N Describe: _____

When did the problem start? _____ How did it originally occur? _____

Has it become worse recently? ❑ Y ❑ N ❑ Same ❑ Better ❑ Gradually worse How frequent is the condition? ❑ Constant ❑ Daily ❑ Intermittent

How long does it last? ❑ All day ❑ Few hours ❑ Minutes Is this condition interfering with your? ❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

Does anything relieve the symptom(s) ❑ Y ❑ N ❑ Medication (prescription or OTC) ❑ Rest ❑ Exercise/Stretch ❑ Other: _____

If no, what have you tried? ❑ Medication (prescription or OTC) ❑ Rest Exercise/Stretch ❑ Surgery

Is there anything that you can do to relieve the symptom? ❑ Y ❑ N ❑ Medication (prescription or OTC) ❑ Rest Exercise/Stretch ❑ Other: _____

If no, what have you tried to do that has not helped? ❑ Medication (prescription or OTC) ❑ Rest ❑ Exercise/Stretch ❑ Surgery ❑ Chiropractic ❑ Other: _____

How long has it been since you really felt good? ❑ Days ❑ Weeks ❑ Months ❑ Years ❑ >10 years

Describe the pain/problem: ❑ Sharp ❑ Dull ❑ Numbness ❑ Tingling ❑ Aching ❑ Burning ❑ Stabbing ❑ Other: _____

What makes the problem worse? ❑ Standing ❑ Sitting ❑ Lying ❑ Bending ❑ Lifting ❑ Twisting ❑ Other: _____

What do you believe is the cause of the problem? _____

Are there any other conditions or symptoms that may be related to your major symptom? ❑ Y ❑ N If yes, what? _____

Please check all of the symptoms that apply. (P=Past/C=Current)

P / C	P / C	P / C	P / C	P / C
❑ ❑ Headache	❑ ❑ High Blood Pressure	❑ ❑ Tingling in Feet	❑ ❑ Facial Pain	❑ ❑ Low Blood Pressure
❑ ❑ Walking Problems	❑ ❑ Eye Pain	❑ ❑ Abdominal Pains	❑ ❑ Sore Muscles	❑ ❑ Blurred Vision
❑ ❑ Nausea/Vomiting	❑ ❑ Weak Muscles	❑ ❑ Dizziness	❑ ❑ Poor Appetite	❑ ❑ Paralysis
❑ ❑ Earache	❑ ❑ Fullness of Bladder	❑ ❑ Shakiness	❑ ❑ Forgetfulness	❑ ❑ Urination Difficulty
❑ ❑ Sweating	❑ ❑ Confusion	❑ ❑ Frequent Urination	❑ ❑ Insomnia	❑ ❑ Sinusitis
❑ ❑ Constipation	❑ ❑ Fainting	❑ ❑ Teeth Grinding	❑ ❑ Hemorrhoids	❑ ❑ Convulsions
❑ ❑ Dry Mouth	❑ ❑ Decreased Sex Drive	❑ ❑ Irritability	❑ ❑ Excessive Thirst	❑ ❑ Menstrual Irregularities
❑ ❑ Impatience	❑ ❑ Unpleasant Taste	❑ ❑ Elbow/Hand Pain	❑ ❑ Fatigue	❑ ❑ Neck Pain
❑ ❑ Tingling in Hands	❑ ❑ Feel Loss of Control	❑ ❑ Sore Throat	❑ ❑ Clammy Hands	❑ ❑ Lump in Throat
❑ ❑ Low Back Pain	❑ ❑ Swallowing Pain	❑ ❑ Hip Pain	❑ ❑ Unsteady Voice	❑ ❑ Knee Pain
❑ ❑ Shoulder Pain	❑ ❑ Poor Circulation	❑ ❑ Persistent Coughing	❑ ❑ Swollen Joints	❑ ❑ Chest Pressure
❑ ❑ Joint Stiffness	❑ ❑ Slow Heart Rate	❑ ❑ Swollen Ankles	❑ ❑ Rapid Heart Rate	❑ ❑ Ankle/Foot Pain
❑ ❑ Other:_____				

Patient's Name: _____ Date: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

❑ Food: ❑ Dairy ❑ Wheat ❑ Corn ❑ Soy ❑ Seafood ❑ Gluten ❑ Peanuts ❑ Fruits ❑ Other: _____

❑ Medications: ❑ Penicillin ❑ Sulfa Drugs ❑ Iodine ❑ Insulin ❑ Antibiotics ❑ Other: _____

❑ Seasonal/Other: ❑ Pollen ❑ Dust ❑ Hay ❑ Mold ❑ Chemical(s) ❑ Smoke ❑ Animals ❑ Insects ❑ Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
❑ Antacids		
❑ Antibiotics		
❑ Antidepressants		
❑ Anti-Diabetics		
❑ Anti-Inflammatory		
❑ Blood Pressure Lowering Meds.		
❑ Cholesterol Lowering Meds.		
❑ Hormone Replacements (HRT)		
❑ Oral Contraceptives		
❑ OTC (over the counter) Other		

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs ❑ Y ❑ N If yes, who recommended them? _____

SCARS/SURGICAL PROCEDURES: Have you had any surgical procedures? ❑ YES ❑ NO Any Scares? ❑ YES ❑ NO

SPINE: ❑ Cervical ❑ Thoracic ❑ Lumbar EXTREMITIES: ❑ Shoulder/Elbow/Hand/Wrist ❑ R ❑ L ❑ Hip/Knee/Ankle/Foot ❑ R ❑ L

ABDOMINAL/CHEST: ❑ Appendix ❑ Colon ❑ Gall Bladder ❑ Heart ❑ Lungs ❑ Breast ❑ Other: _____

HABITS:	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Soda/Diet Soda	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Stress Level	❑	❑	❑	❑

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Exercise	❑	❑	❑	❑	❑ Aerobic ❑ Weights
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	❑	❑	❑	❑	❑
	5+	4	3	2	
Meals/day	❑	❑	❑	❑	❑
	64+ oz	32-64 oz	16-32 oz	<8 oz	
Water/day	❑	❑	❑		

WORK ACTIVITY: ❑ Heavy Labor ❑ Light Labor ❑ Mostly Sitting ❑ Mostly Standing ❑ Walking/Moving ❑ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(F=Family, P=Personal History)

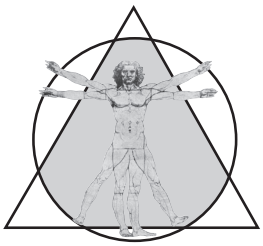
____ Alcoholism
____ Anemia
____ Cancer
____ Cold Sores
____ Deep vein thrombosis
____ Detached retina
____ Diabetes
____ Eczema
____ Emphysema
____ Epilepsy
____ Goiter
____ Gout
____ Heart Disease
____ HIV/AIDS
____ Miscarriage(s)
____ Mumps
____ Pleurisy
____ Pneumonia
____ Polio
____ Rheumatic Fever
____ Stroke
____ Tumor(s)
____ Ulcer(s)
____ Other: _____

_____ Patients Printed Name

_____ Patient's Signature

_____ Date:

Reviewed By: _____ Date: _____



CHAMBUL WELLNESS CENTER

Consent to Treatment

I wish to receive examinations and treatment at Chambul Wellness Center. I therefore authorize examination and treatment to be performed by the staff at Chambul Wellness Center.

Patient Signature _____ Date _____

If Patient is under 18 years of age, Patient/Guardian Signature

_____ Date _____

Patient Billing Information

I understand that all payments are due to **Chambul Wellness Center** at the time services are rendered, except when prior arrangements are made. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Initial Consultation: Initial consultation does not include any exams or x-rays).
X-ray services are subject to separate outside fees. All fees are subject to change without notice.

Note: Manipulation is the only covered Chiropractic service by Medicare. A charge of $25.00 will be assessed for a missed appointment. We require a 24-hour notice for cancellations.

Any financial arrangements are to be determined prior to services rendered.

I agree to the terms above, and acknowledge that in the event that there is an outstanding balance, which fails to be cured within 120 days, my account with **Chambul Wellness Center** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

_____ _____

Signature Date