Welcome

Patient Information:

Date: _____

Name: _____
Last First MI What would you like to be called?

Email Address: _____

Mailing Address: _____

_____

Phone #: _____ _____ _____
Cell Work Home (if applicable)

Can we call you at work? (*Circle one*) Yes No

Date of Birth: _____ Sex (*Circle one*): Male Female SS#: _____

Marital Status (*Circle one*): Single Married Divorced Widowed Separated

Occupation: _____ Employer: _____

Employer Address: _____

_____

Employer Phone #: _____

How did you hear about our practice?: _____
Please provide a name if referred by a person

Emergency Contact: Name: _____ Relation: _____ Phone #: _____

Accident Information:

Is this visit due to an accident? (*Circle one*) Yes No

If yes, what type? (*Circle one*) Auto Work Other _____

Has it been reported? (*Circle one*) Yes No

If yes, to whom? _____

Financial Information:

Name of person responsible for this account? _____

What is the birth date for the person responsible for this account? _____

Relationship to the patient *(if other than self)*?: _____ Phone #:_____

Do you have health insurance? (*Circle one)*: Yes No Name of Carrier: _____

Do you have secondary insurance? (*Circle one)*: Yes No Name of Carrier: _____

PLEASE PROVIDE OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients):

I certify that I (or my defendant) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature: _____ Date: _____

Health History:

Who is your primary care physician? _____

(doctor and/or practice)

Primary Care Physician Address: _____

_____

Phone #: _____

Please check to indicate if you are currently experiencing any of the following conditions:

	Neck Pain / Stiffness		Pins / Needles in Arms		Light Bothers Eyes		Sudden Weight Loss		Nausea
	Back Pain / Stiffness		Pins / Needles in Legs		Depression		Loss of Taste		Cold Feet
	Arm / Hand Pain		Fatigue		Nervousness		Loss of Memory		Chest Pain
	Leg / Knee Pain		Sleeping Difficulties		Tension		Jaw Problems		Fever
	Headaches		Loss of Smell		Cold Sweats		Constipation		Fainting
	Dizziness		Allergies		Stomach Problems		Shortness of Breath		
	Asthma		Blurred Vision		Night Pain		Bowel / Bladder Changes		

Please check to indicate if you have ever had any of the following:

	Aids / HIV		Cataracts		Hernia		Pacemaker		Thyroid Problems
	Alcoholism		Chemical Dependency		Herniated Disc		Parkinson's Disease		Tonsillitis
	Allergy Shots		Chicken Pox		Herpes		Pinched Nerve		Tuberculosis
	Anemia		Diabetes		High Cholesterol		Pneumonia		Tumors / Growths
	Anorexia		Emphysema		Kidney Disease		Polio		Typhoid Fever
	Appendicitis		Epilepsy		Liver Disease		Prostate Problems		Ulcers
	Arthritis		Fractures		Measles		Prosthesis		Vaginal Infections
	Asthma		Glaucoma		Migraines		Psychiatric Care		Venereal Disease
	Bleeding Disorders		Goiter		Miscarriage		Rheumatoid Arthritis		Whooping Cough
	Breast Lump		Gonorrhea		Mononucleosis		Rheumatic Fever		
	Bronchitis		Gout		Multiple Sclerosis		Scarlet Fever		
	Bulimia		Heart Disease		Mumps		Stroke		
	Cancer		Hepatitis		Osteoporosis		Suicide Attempt		

Other *(not listed above)*: _____

_____

Are you currently under medical care? Or taking drugs? *(Circle one)* Yes No

If yes, explain: _____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any surgeries and/or hospitalizations you have had *(type & date)*: _____

_____

_____

Please list any allergies: _____

_____

Please list any supplements you are taking *(vitamins/herbs/minerals)*: _____

_____

Is there a family history of the following conditions? *(Indicate which family member including parents, grandparents, & siblings):*

	Heart Disease: _____ _____			Diabetes: _____ _____
	Cancer: _____ _____			Arthritis: _____ _____

Other *(not listed above)*: _____

_____

	Frequently	Moderately	Occasionally	Never
How often do you exercise?				
How often do you utilize alcohol?				
How often do you smoke cigarettes?				

How often do you feel your symptoms? *(Circle one)*

Constant *(76 – 100%)* Frequent *(51 – 75%)*

Occasionally *(26 – 50%)* Intermittently *(0 – 25%)*

Rate how bad your symptoms are *(0-no pain; 10-worst pain)*:

No pain - 0 1 2 3 4 5 6 7 8 9 10 – *Worst Pain*

What activities make your pain worse?: _____

_____

What activities reduce your symptoms?: _____

_____

Do you sleep on your . . .: (*Circle one)* Back Side Stomach

Do you use a cervical pillow? (*Circle one)* Yes No

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____

DATE: _____

NEW YORK – NO FAULT ACCIDENT QUESTIONNAIRE

Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____

Sex (*Circle one):* Male Female SS#: _____

Marital Status (*Circle one*): Single Married Divorced Widowed Separated

Phone #: _____ _____ _____
Cell Work Home (if applicable)

AUTO INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Address: _____

Agent: _____ Policy #: _____

Claim #: _____

Time & Date of Accident: _____

AUTO ACCIDENT INFORMATION:

Please describe the accident: _____

_____

_____

Was there a police report? (*Circle one*) Yes No What direction was your car struck from?: _____

Were you a driver or passenger?: _____ Knocked unconscious? (*Circle one*) Yes No

Were you wearing a seatbelt? (*Circle one*) Yes No Hospitalized? (*Circle one*) Yes No

X-Rays / Tests Taken?: (*Circle one*) Yes No If yes, where?: _____

Diagnosis & Treatment: _____

_____

Have you seen any other doctors for this condition? (*Circle one*) Yes No If yes, when? _____

Please describe your pain immediately after the accident and your present complaints: _____

_____

_____

Since the injury, are your symptoms: (*Circle one*) Improving Getting Worse The Same

Are your work activities restricted as a result of this accident? (*Circle one*) Yes No

Have you retained an attorney? (*Circle one*) Yes No If yes, who?: _____

NEW YORK VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor"), hereby assign to _____, DC ("Assignee")
(Print Patient's Name) *(Print hospital or health care provider name)*
All rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding
(Print Accident Date)
any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) *(Signature of Patient)*

_____ _____
(Date of Signature)

_____
(Address of Patient)

_____, DC _____
(Print name of Provider) *(Signature of Provider)*

6332 S. Transit Road _____
(Date of Signature)

Lockport, New York 14094
(Address of Provider)

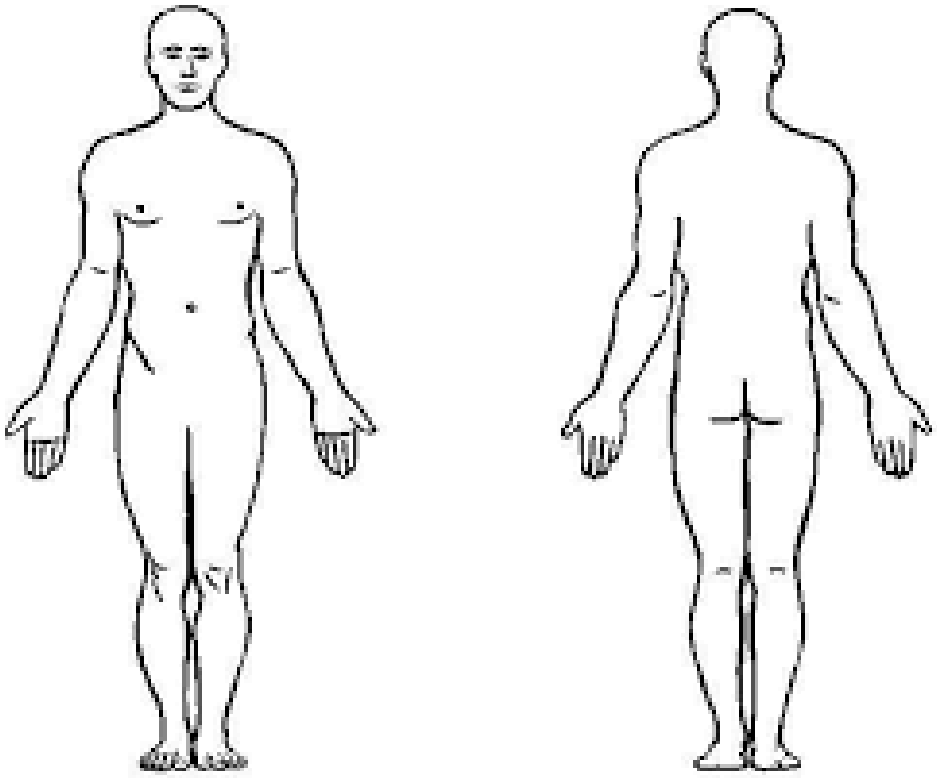
NYS FORM NF-AOB (Rev 1/2004)

PATIENT PAIN DIAGRAM

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
//////	▬▬	● ● ● ●	XXXX	△△△△	○○○○



Is your pain aggravated by any of the following? (*Circle all that apply)*

Coughing or Sneezing	Sitting in a Chair	Bending forward to brush teeth
When you wake up	In the middle of the night	Lying flat on your back
Lying flat on your stomach		

Height: _____

Weight: _____

Are you . . .: (*Circle one)* Right Handed Left Handed

NOTICE OF PRIVACY PRACTICES
OF
Total Body Wellness and Chiropractic

Total Body Wellness and Chiropractic (hereinafter referred to as TBW) must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *TBW* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care, and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within TBW, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights in regards to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures TBW uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have received TBW's *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

_____ _____

Client (or Personal Representative) Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____

Printed Name

_____

Signature

_____

Date