Welcome

Date: _____

Patient Information

Name: _____
Last First MI

Email Address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____(W)_____(Other)_____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other:_____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Non-Hispanic/ Non-Latino

Occupation: _____ Employer:_____

Employer Address: _____ Phone:_____

How did you hear about our practice?_____

Emergency Contact: Name:_____Relation:_____

Phone#:(C)_____(H)_____(W)_____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other_____

Has is been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____D.O.B :_____

Relationship to Patient (if other than self): _____ Phone#:_____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ 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 dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for 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 (X) _____ **DATE** _____

Health Questionnaire

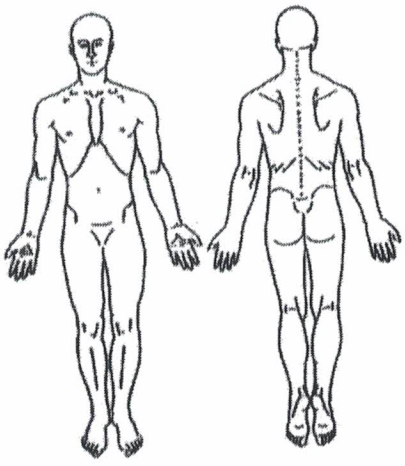
Name:_____ Age:_____ DOB:_____

Occupation:_____ #Hours/week currently working_____

Check off any of the following symptoms you have experienced in the past 6 months:

- ❑ Neck Pain
- ❑ Headaches
- ❑ Tension across top of shoulders
- ❑ Numbness/Tingling in arms/hands
- ❑ Carpal Tunnel
- ❑ Pain in between shoulder blades
- ❑ Difficulty Sleeping
- ❑ Allergies
- ❑ Low Back Pain
- ❑ Numbness/Tingling in legs/feet
- ❑ Pain in Legs
- ❑ Pain in Feet
- ❑ Fibromyalgia
- ❑ Tired/Fatigued
- ❑ Digestive Problems

Other: _____



(Circle areas of symptoms/pain/discomfort)

Which of the above is/are your MAJOR PROBLEM(S) and what do(es) it/they FEEL like? (Health)

1. _____
2. _____
3. _____
4. _____

How long/often have/do you find yourself suffering from this problem? (For Each)
(Constant: 100%-75%; Frequent: 75%-50%; Intermittent: 50%-25%; Occasional: 25%-1%) & (Times per week/Month)

1. _____
2. _____
3. _____
4. _____

Was there an earlier accident, injury that is directly related to this problem? (fall, auto injury, work injury, sports injury, repetitive motion on the job)

1. _____
2. _____
3. _____
4. _____

Discomfort Increases with: (Check all that apply)

❑ Movement ❑ Applied Pressure ❑ Prolonged Sitting ❑ Coughing/Sneezing

Other: _____

What have you tried that has helped this problem? (Check all that applied)

❑ Ice ❑ Heat ❑ Rest ❑ Over the counter medications ❑ Stretching ❑ Chiropractic ❑ PT ❑ Massage

Other:_____

Circle the following

Medications helped:	Little	Some	Much
Exercise helped:	Little	Some	Much
Physical Therapy helped:	Little	Some	Much
Nutrition helped:	Little	Some	Much
Chiropractic helped:	Little	Some	Much
Stretching helped:	Little	Some	Much

Has anything you have tried thus far fixed your problem? ❑ Yes ❑ No

What activities would you like to do if this was not a problem?

_____

_____

Does this issue cause you to be?

- ❑ Moody
- ❑ Irritable
- ❑ Interrupt Sleep
- ❑ Restricted in your daily activities

Does this affect your work?

- ❑ Decision making
- ❑ Poor attitude
- ❑ Decreased Productivity
- ❑ Exhausted at the end of day
- ❑ Unable to work long hours

Does this affect your life?

- ❑ Lose patience with spouse/children
- ❑ Restricted household duties
- ❑ Hinders ability to exercise/sports
- ❑ Interferes with hobbies/activities

I consent to receive a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the physician and/or clinic from any damage resulting from this demonstration.

Name:_____ Date:_____

Review of Systems

Name:_____ DOB: _____ Date:_____

Y	N	Neurological
_____	_____	Migraines
_____	_____	Headaches
_____	_____	Slurring of Speech
_____	_____	Ringing in Ear
		Ear/Nose/Throat
_____	_____	Altered taste/smell
_____	_____	Night Blindness
_____	_____	Sore Throat
_____	_____	Gingivitis
_____	_____	Nose bleeds
		Cardiovascular
_____	_____	Chest pain
_____	_____	Palpitations-racing heart beat
_____	_____	Swelling in hands/feet
_____	_____	Anemia
		Respiratory
_____	_____	Recurrent Respiratory Infections
_____	_____	Asthma
_____	_____	Chest Congestion
_____	_____	Wheezing
_____	_____	Frequent Sneezing
		GI
_____	_____	Stomach Pains or Cramping
_____	_____	Constipation
_____	_____	Reflux or Heartburn
_____	_____	Bloating
_____	_____	Gas
_____	_____	Nausea or Vomiting
		Musculoskeletal
_____	_____	Joint Pain
_____	_____	Arthritis
_____	_____	Chronic Pain
_____	_____	Muscle aches

Y	N	Skin
_____	_____	Eczema
_____	_____	Dermatitis
_____	_____	Excessive Sweating
_____	_____	Rashes
_____	_____	Brittle Nails
_____	_____	Hair Loss
_____	_____	Easy Bruising
_____	_____	Increased Bleeding
_____	_____	Numbness/tingling
		Genitourinary
_____	_____	Uterine Fibroids
_____	_____	Ovarian Cysts
_____	_____	Cancer (breast, ovarian, prostate, uterine)
_____	_____	Prostate Problems
		Emotional/Mental
_____	_____	Depression
_____	_____	Anxiety
_____	_____	Mood Swings
_____	_____	Irritability
_____	_____	Memory Loss
_____	_____	Confusion
		Energy
_____	_____	Fatigue
_____	_____	Hyperactivity
_____	_____	Restlessness
_____	_____	Insomnia
_____	_____	Decreased Libido
_____	_____	Stress
		Weight
_____	_____	Decreased Appetite
_____	_____	Weight Gain
_____	_____	Inability to Lose Weight
_____	_____	Food Cravings
_____	_____	Binge Eating
_____	_____	Water Retention

Informed Consent To Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Gauck Chiropractic and Wellness. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time.

I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date