Date:

Wolff Chiropractic Wellness Center

Personal History

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth_____ Age: _____ Sex ○M ○ F

Cell Phone: _____ Email: _____ Contact Via: TEXT EMAIL

Social Security #: _____ Driver License # _____

Check One: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated Cell Carrier _____

Business Employer and Phone #: _____ Type of work: _____

Name of Spouse: _____ Spouse's Employer: _____

***Referred to this Office By: _____ ***

Emergency Contact: _____ Relationship: _____ Phone: _____

Guardian Name: _____ Phone: _____

Who is Responsible for your Bill, ○you and/or Spouse ○ Workers Comp. ○ Auto Insurance ○ Medicare

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What Brought You In Today?

Major Complaint: _____

Condition Began: Month _____ Date: _____ Time: _____ Constant Pain YES NO

Has this condition occurred before? ○ Yes ○ No If Yes. When? _____

Other Doctors Seen for this Condition? ○Yes ○No If yes, Who? _____

Type of Treatment_____ Results: _____

Is Condition: ○ Auto Accident ○ Home Injury ○ Fall ○ Other

If other please explain_____

Drugs You Now Take: ○Nerve Pills ○ Pain Killers/Muscle Relaxers ○Blood Pressure Medicine ○ Insulin

○ Other: _____ Do You Wear foot Orthotics or Shoe Lift? ○ Yes ○ No

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Past Health History

Please Check and Describe:

Major Surgery/Operations: ○ Appendectomy ○ Tonsillectomy ○ Gall Bladder ○ Hernia ○Back Surgery

○ Conditions you have/had _____

○ Other_____

Major Accidents or Falls _____

Hospitalization (Other Than Above): _____

Past Chiropractic Care: ○None ○ Name and Approximate Date of Last Visit:_____

What is your level of commitment to yourself, your life, and your well-being?

○ High ○ Medium ○ Low

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

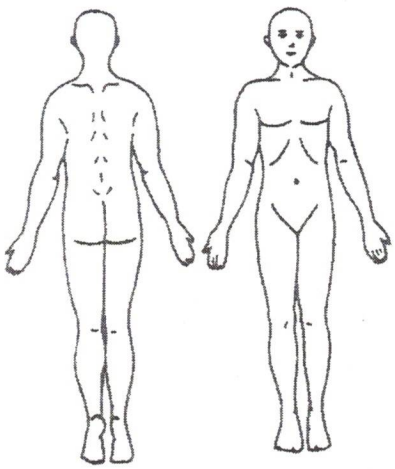
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

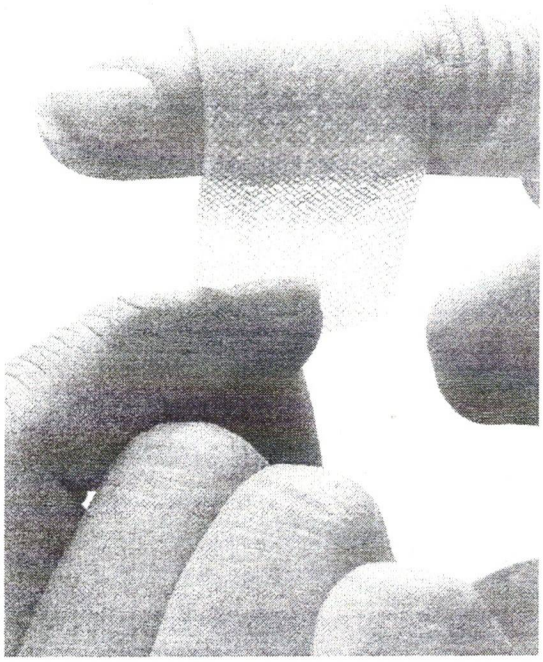
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

Date _____ Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ *Date* _____

Consent to Treat a Minor _____ *Date* _____

Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

Chiropractic Consent Form

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me by _____.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

- ☐ Sure! You can use my picture on the Straightahead Website and Social Media (i.e. Facebook, Instagram, etc.) pages, as long as I look good in it!
- ☐ No thanks! I'll pass for now.

X-RAY RELEASE AND CONSENT

It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. Please select from the following:

- ☐ Sure! Do whatever you feel is necessary to come up with the best care plan for me (and, NO, I am certainly NOT pregnant).
- ☐ No thanks! I'll pass for now, as I am pregnant or have another medical condition which contradicts me being exposed to x-ray.

I attest that the information on this form, and those preceding, is true and accurate to the best of my knowledge.

_____

Printed Name of Patient

_____

Signature of Patient Date

_____

Signature of Representative (if patient is a minor or has disability) Date