Creating Wellness™

Your Wellness History – Health Profile

Date: ____________

Name: _________________________________ **DOB:** __________ **Age:** _____/ **Male Female**

Address: ____________________________________ **City:** ______________________ **State:** ____ **Zip:** _______

Home # ( )_________________ **Work: ( )**___________________ **Cell: ( )**_____________________

Best time to contact: ____________________

Email address: ____ **Status: Single Married Divorced Widowed**

# of Children: _____ **Names/Age:** ____

Occupation: __________________ **Employer Name/Address:** ____

Rate your health and wellness.

Place an '**X**' that denotes where you believe is your current level of wellness.

Place an '**O**' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

- What brings you into our office today?

Please briefly describe, including the impact if has had on your life.

Rate Severity (scale 1-10, 1being mild) When and how did this start? Are symptoms constant or intermittent?

____

____

____

- Since the problem started it is; ___the same ___getting better ___ getting worse

What makes the problem worse?____

____

- What, if anything, makes the problem feel better?______________________________________

____

- Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

____

- Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: ____ Date: ____________

What was the diagnosis: ____

ATLANTIS CHIROPRACTIC WELLNESS CENTERS

1 Teal Road
Wakefield, MA 01880
781 – 224-202

GENERAL HISTORY

➢ Please list all medications you are taking, (Including any supplements).

____

____

____

➢ Have you had any surgeries and/or hospitalizations? ___Yes ___No

If yes, briefly explain:____

____

➢ Have you ever had any work related injuries? ___Yes ___No

If yes, briefly explain: ____

____

➢ Have you ever had any slips, falls or auto accidents? ___Yes ___No

If yes, briefly explain:____

____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

❑ Headaches	❑ Buzzing in ears	❑ Irritability	❑ Diarrhea
❑ Pins & needles in arms	❑ Ringing in ears	❑ Cold hands	❑ Cold sweats
❑ Pins & needles in legs	❑ Numbness in toes	❑ Cold feet	❑ Mood Swings
❑ Dizziness	❑ Depression	❑ Fever	❑ Loss of smell
❑ Numbness in fingers	❑ Constipation	❑ Urinary problem	❑ Loss of taste
❑ Fatigue	❑ Menstrual pain	❑ Fainting	❑ Back pain
❑ Sleeping problems	❑ Menstrual irregularity	❑ Eyes bothered by light	❑ Neck Pain
❑ Tension	❑ Hot flashes	❑ Stomach upset	❑ Stiff neck
❑ Ulcers			

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and you understand that...

You may be contacted by: phone, at home or work, mobile phone, e-mail or letter.
Messages may be left for you: on answering machine/voicemail at home, work and on mobile phone or with individuals answering your phone at home or work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone having access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years form the date I last received services in this office.

Patient (or Personal representative) Signature **Date**

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Notice of Privacy Practices for protected Health Information of Martone Chiropractic Wellness Center.

Patient (or Personal representative) Signature **Date**

Authorization to Utilize Testimonial

Seeing our patients enjoy good health is our primary goal. Many patients have let us know the improvements they've experienced in their overall health and well being since starting Chiropractic care. If you enjoy better health, we'd love to know and let others have the opportunity to be encouraged by your success. I, the undersigned, give permission to Martone Chiropractic Wellness Center to utilize my name, picture and testimonial to help educate others about the benefits of Chiropractic care. My name, picture and testimonial may be reproduced in any part or in full as an aid to understanding the science of Chiropractic care.

Patient (or Personal representative) Signature **Date**

Authorization to Release and Pay Benefits Direct

I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Martone Chiropractic Wellness Center, to be applied towards my account. I am also aware that I will be responsible for paying any balance on my account, including co-pays, co-insurance, deductibles, and for any non-covered services. I also authorize Martone Chiropractic Wellness Center to furnish information to my insurance company regarding my care and treatment in a manner consistent with the privacy policies of this office in obtaining payment for services provided.

Patient (or Personal representative) Signature **Date**

Personal representative – Printed **Description of personal representative's authority to act for the patient.**

Authorized Provider Representative (Office) **Date (Office)**

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:____

Signature of Patient:____

Name Printed of Guardian/Parental and Relationship to Patient:______________________

Guardian/Parental Signature:____

Date:____________________