CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply on this form is confidential. This office complies with all federal health information privacy standards.

Please print legibly.

Woosley Chiropractic Rehab and Wellness Center, PC
Suite 104
913 Conference Drive
Goodlettsville, TN 37072
(615) 933-7246

Today's Date

Have you consulted a chiropractor before?
O No O Yes **When?** _____

Patient Number (office use)

Whom may we thank for referring you?

If so, whom?

Your Last Name | **Your Social Security #** | **Birth Date** | **Age**

Your First Name | **Your Middle Name** | **Gender** O Male O Female | **Race**

Address | **Marital Status** O Married O Single O Divorced O Widowed | **Ethnicity**

City | **State/Province** | **Zip Code** | **Language**

Home Phone | **Cell Phone** | **Spouse's Name**

Email Address | **Child's Name & Age**

Emergency Contact | **Emergency Contact's Phone** | **Child's Name & Age**

Your Occupation | **Child's Name & Age**

Your Employer | **Work Phone**

Employer Address

May we contact you at work?
O Yes O No

City | **State/Province** | **Zip Code**

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email Address

Primary Care Provider's Name

Insurance Carrier | **Policy Number**

Insured's Last Name | **Birth Date**

Who carries this policy?
O Self O Spouse O Parent

Insured's First Name | **Insured's Middle Name**

Insured's Employer | **Group Number**

CONFIDENTIAL HEALTH INFORMATION

CHIROPRACTIC QUESTIONNAIRE

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. My symptom(s) is/are a result of (please circle): O An accident/injury

O Work O Auto O Other: _____

O A worsening long-term problem

O An interest in: O Wellness O Other: _____

3. When did you first notice your symptoms? _____

4. How would you rate your current symptoms?

0 O—O—O—O—O—O—O—O—O—O—O—O 10
Absent Uncomfortable Severe

5. Duration and timing (when did it start and how often do you feel it?)

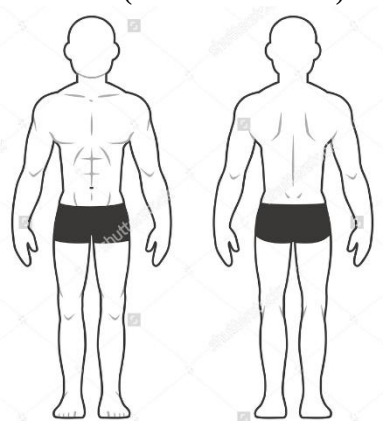
O Constant O Comes and goes. How often? _____

6. Quality of symptoms (please check all that apply that describe your pain):

O Numbness	O Tingling	O Stiffness	O Dull
O Aching	O Cramps	O Nagging	O Sharp
O Burning	O Throbbing	O Shooting	O Stabbing

O Other: _____

7. Location (where does it hurt?)



Please circle the area(s) on the illustration.

Use "O" for current symptoms.

Use "X" for conditions you have experienced in the past.

8. Radiation (Does it affect other areas of your body? Ex. Legs/arms.)

_____

9. Aggravating or relieving factors

What tends to worsen your pain/condition? _____

What tends to lessen your pain/condition? _____

10. Prior interventions (What have you tried/done to relieve your symptoms? Please check all that apply.)

O Prescription medication	O Surgery	O Ice	O Over-the-counter drugs	O Acupuncture
O Homeopathic remedies	O Heat	O Chiropractic care	O Physical therapy	O Massage

O Other: _____

11. What else should Woosley Chiropractic know about your current condition?

_____

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting/desk work/driving	O	O	O	O
Rising out of chair/car	O	O	O	O
Prolonged standing	O	O	O	O
Walking	O	O	O	O
Lying down	O	O	O	O
Exercising	O	O	O	O
Climbing stairs	O	O	O	O
Household chores	O	O	O	O
Lifting objects	O	O	O	O
Reaching overhead	O	O	O	O
Showering/dressing	O	O	O	O
Sleeping	O	O	O	O
Bending over	O	O	O	O
Looking over shoulder	O	O	O	O

What is the major stressor in your life? _____

How much sleep do you average per night? _____

Type and age of mattress/pillows? _____

Preferred sleeping position? _____

Describe your typical eating habits: O Skip Breakfast O Two meals a day O Three meals a day O Snacking between meals

What would be the most significant thing that you could do to improve your health? _____

In addition to the main reason, what additional health goals do you have? _____

MEDICAL QUESTIONNAIRE

Medical History

Please take the time to review all medical history questions, as they are pertinent to government and insurance requirements.

Review of Systems

CONSTITUTIONAL
- Chills O YES O NO
- Fever O YES O NO
- Weight Loss O YES O NO
- Decline in health O YES O NO
- Other: _____

HEAD
- Dizziness O YES O NO
- Headaches O YES O NO
- Fainting O YES O NO
- Head injuries O YES O NO
- Other: _____

EYES
- Blurry vision O YES O NO
- Double vision O YES O NO
- Cataracts O YES O NO
- Glaucoma O YES O NO
- Discharge O YES O NO
- Other: _____

EAR/NOSE/THROAT
- Colds O YES O NO
- Nosebleeds O YES O NO
- Changes in teeth O YES O NO
- Ringing in ears O YES O NO
- Ear infections O YES O NO
- Hearing aids O YES O NO
- Ear pain O YES O NO
- Other: _____

RESPIRATORY
- Asthma O YES O NO
- Sputum O YES O NO
- Bronchitis O YES O NO
- Shortness of breath O YES O NO
- Coughing O YES O NO
- Other: _____

CARDIOVASCULAR
- Hypertension O YES O NO
- Heart attacks O YES O NO
- Swelling of legs O YES O NO
- Palpitations O YES O NO
- Other: _____

GASTROINTESTINAL
- Abdominal pain O YES O NO
- Nausea/Vomiting O YES O NO
- Diarrhea O YES O NO
- Constipation O YES O NO
- Jaundice O YES O NO
- Other: _____

MUSCULOSKELETAL
- Arthritis O YES O NO
- Back/neck pain O YES O NO
- Restricted motion O YES O NO
- Muscle cramps O YES O NO
- Joint pain O YES O NO
- Other: _____

PSYCHIATRIC
- Depression O YES O NO
- Memory loss O YES O NO
- Hallucinations O YES O NO
- Other: _____

BREASTS
- Lumps O YES O NO
- Tenderness O YES O NO
- Discharge O YES O NO
- Self-examination O YES O NO
- Other: _____

SKIN
- Eczema O YES O NO
- Bruise easily O YES O NO
- Skin color changes O YES O NO
- Hives O YES O NO
- Other: _____

NEUROLOGICAL
- Numbness/tingling O YES O NO
- Fainting O YES O NO
- Headaches O YES O NO
- Dizziness O YES O NO
- Other: _____

ENDOCRINE
- Fatigue O YES O NO
- Muscle weakness O YES O NO
- Weight gain/loss O YES O NO
- Excessive urination O YES O NO
- Other: _____

HEMATOLOGIC/LYMPH
- Anemia O YES O NO
- Swollen glands O YES O NO
- Bleeding easily O YES O NO
- DVT/blood clots O YES O NO
- Other: _____

ALLERGIES/IMMUNOLOGIC
- Coughing/sneezing O YES O NO
- Recurrent infection O YES O NO
- Wheezing O YES O NO
- Itchy/watery eyes O YES O NO
- Other: _____

GENITOURINARY
- High frequency O YES O NO
- Pain with urination O YES O NO
- Kidney stones O YES O NO
- Blood in urine O YES O NO
- UTIs O YES O NO
- Other: _____

OTHER

Please list any other medical concerns below.

_____
_____
_____
_____

Surgeries/Operations

Please mark or list all past surgical interventions, which may or may not have included hospitalization.

O Appendectomy O Mastectomy O Hysterectomy O Vasectomy O Eye surgery: _____

O Heart Surgery: _____ O Knee replacement: LEFT RIGHT O Hip replacement: LEFT RIGHT O Cervical disc fusion: C1-C2-C3-C4-C5-C6-C7-T1 O Lumbar disc fusion: L1-L2-L3-L4-L5-S1

O Carpal Tunnel O Other: _____

Medications

Medication/Vitamin Name	Dosage	Frequency
1.		
3.		
5.		
7.		

Medication/Vitamin Name	Dosage	Frequency
2.		
4.		
6.		
8.		

Attach a separate sheet or use reverse side of this sheet for additional medications if needed.

Allergies **O No Known Allergies**

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

MEDICAL/CHIROPRACTIC QUESTIONNAIRE

Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age (if living)	State of Health		Illnesses	Age at Death	Cause of Death	
		Good	Poor			Natural	Illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister 1	_____	O	O	_____	_____	O	O
Sister 2	_____	O	O	_____	_____	O	O
Brother 1	_____	O	O	_____	_____	O	O
Brother 2	_____	O	O	_____	_____	O	O

Are there any other hereditary issues that you know about? _____

Social History

Tell us about your health habits and stress levels.

Alcohol use:	O Daily	O Weekly	How much? _____	Prayer or meditation?	O YES O NO
Coffee use:	O Daily	O Weekly	How much? _____	Job pressure/stress?	O YES O NO
Tobacco use:	O Daily	O Weekly	How much? _____	Financial peace?	O YES O NO
Exercising:	O Daily	O Weekly	How much? _____	Mercury fillings?	O YES O NO
Pain relievers:	O Daily	O Weekly	How much? _____	Recreational drugs?	O YES O NO
Soft drinks:	O Daily	O Weekly	How much? _____	Are you vaccinated?	O YES O NO
Water Intake:	O Daily	O Weekly	How much? _____	If yes, when? _____	

Acknowledgements and Informed Consent of Treatments

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial each.

_____ initial — I instruct the chiropractor and/or nurse practitioner to deliver the care that, in his/her/their professional judgment(s), can best help me in the restoration of my health. I also understand that the treatment offered in this practice is based on the best available evidence and designed to reduce my symptoms and, specifically to chiropractic care, correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ initial — **Cervical/neck adjustments and stroke.** Numerous studies show that there is no correlation between a cervical adjustment and a stroke; however, although extremely rare, patients have experienced a stroke following a visit to a chiropractor in the past. Dr. Woosley is highly trained and performs dozens of spinal adjustments each week and assures that all applicable medical history and a comprehensive review of your symptoms is done to establish a treatment plan that best suits your needs. Chiropractic manipulations are very safe and effective in the treatment of musculoskeletal conditions. Should you have any questions or concerns regarding this correlation, please feel free to address them prior to treatment.

_____ initial — **Dry needling treatment.** Dr. Woosley is trained in trigger point dry needling therapy. This treatment, loosely related to acupuncture, utilizes needles inserted into the muscle to help relieve pain and increase range of motion. As with all forms of medical treatments, there are potential risks and side effects, most notably and most rare being the accidental puncturing of a lung. Under skilled hands, this is not an issue. Other side effects include bruising, infection, and nerve injuries. Separate brochures are available for a more in-depth review into this treatment and its side effects/risks. Your acknowledgement here does not guarantee that this treatment will be performed and is used strictly as notification of this available treatment and its potential, although rare, side effects. **Please alert the provider if you have a disease transferrable through blood/bodily fluids. This treatment is NOT covered by health insurance companies and is $30.00 in addition to co-payments, co-insurance, and deductibles.**

_____ initial — I may request a copy of the Privacy Policy and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ initial — I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period: _____.

_____ initial — I grant permission to be contacted to confirm or reschedule appointments, and to be sent any correspondence in any format related to my care.

_____ initial — I acknowledge that any insurance I may have is an agreement between the carrier and myself, and that I am responsible for the payment of any covered and non-covered services I receive. Benefits quoted by any staff is not a guarantee of payment and may or may not reflect the actual balance owed. Please check all correspondence/EOBs related to your date(s) of service from your insurance company to confirm any balance owed.

_____ initial — To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of any of the health concern(s) outlined in this medical questionnaire.

If patient is a minor, please print his/her name: _____

Signature: _____ Today's Date: _____

WOOSLEY CHIROPRACTIC, REHAB & WELLNESS

Charlton Woosley, Sr., DC

FINANCIAL POLICY

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies. Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your insurance plan, or if your out-of-network insurance plan has coverage that will benefit you. Your benefits will be verified by a staff member, and we will be happy to answer any questions you may have regarding your insurance benefits.
- If you are covered by a State or Federal program with a mandated fee schedule (e.g. Medicare). For Medicare patients, coverage is limited to spinal manipulation ONLY for chiropractic patients. Medicaid/TennCare does not cover chiropractic, and the prompt payment fee schedule would apply (see below).
- If you are eligible and choose a payment plan that allows for "prompt payment" discounts. This prompt payment discount program is found below and will need to be signed if this contract is initiated between you and our office. Fees on this prompt payment fee schedule must be paid at time of service in order to receive this discount.

As part of our compliance plan, as of May 15, 2017, our office will be unable to extend any type of discounts other than those listed on this financial policy.

Acknowledged by: _____ Date: _____

PROMPT PAYMENT DISCOUNT PLAN

(please read and sign ONLY if you have no insurance, or if you have Medicare)

This prompt payment discount plan is for underinsured and uninsured patients, as well as Medicare/Medicaid patients. This discount plan will remain in effect unless another provision in the financial policy is satisfied (i.e. patient obtains health insurance).

SERVICE TYPE	OUR CHARGE	DISCOUNTED FEE
New Patient Exam	$95-$140	$50
Established Patient Exam	$50-$90	$35
X-rays	$50-$70	$40
Spinal Adjustment	$60-$65	$50
Therapeutic Modalities	$30-$50	$10-$30

*** Note for Medicare Patients signing this Prompt Payment Agreement:**

Spinal adjustments are covered by Medicare, which is billed at the "Our Charge" fee listed above. A balance may result from this service. This balance will be billed to you once all claims have been received from both Medicare and your supplemental insurance policy, if applicable. Therapeutic modalities on follow-up visits will be considered out-of-pocket costs and are paid at the discounted fee above. Please ask our staff for more information.

Acknowledged by: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA) and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please Print) Today's Date

_____

Parent, Guardian, or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT CHART AND MAINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize a release of protected health information (PHI) without your prior written consent.

Name of Authorized Representative	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____