UPDATE

CONFIDENTIAL HEALTH INFORMATION

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

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.

UPDATED PERSONAL INFORMATION

First name: _____ **MI**: _____ **Last name**: _____ **Preferred**: _____

Address: _____ **City/State/Zip**: _____

Date of birth: _____ / _____ / _____ **Age**: _____ **Gender**: □ Male □ Female □ Unspecified **SSN**: _____

Primary phone: _____ □ Cell □ Home □ Work **Secondary phone**: _____ □ Cell □ Home □ Work

Email Address: _____ *We do not send out promotional materials or share this info.*

Emergency Contact (Name, Relationship, Phone#): _____

Employer: _____ **Occupation:** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed **Spouse's Name**: _____

Please provide us with updated insurance card(s) for your file if they have changed since your last appointment.

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I certify that I, and/or my dependents, have insurance with the information provided and assign directly to Woosley Chiropractic, PC, all benefits from my insurance company. Any deductible, co-insurance, and co-payment amounts are due at the time of service. I understand that my insurance benefits outlined to me are not a guarantee of payment, and that Woosley Chiropractic may bill me for any balances due if the benefits of my insurance are different than what is expected/quoted to me during my visit. We strongly encourage that you reference any and all correspondence sent to you by your insurance to ensure that payments paid at our office are accurate. If insurance is not filed, I understand that payment is required at the time of service to receive the in-office discount.

Signature: _____ **Today's Date**: _____

REASON FOR TODAY'S VISIT

Where are your symptoms located? _____

Have you had a recent accident/injury? □ Yes □ No If yes, please describe and give dates: _____

_____

When did you first notice your symptoms? _____ **Have we treated you for this symptom before?** □ Yes □ No

Please rate your symptoms that occur <u>constantly</u>: No pain (0) O—O—O—O—O—O—O—O—O—O—O Severe pain (10)

What activities/movements increase your symptoms (e.g. sitting, standing)? _____

Please rate your symptoms <u>when this activity is performed</u>: No pain (0) O—O—O—O—O—O—O—O—O—O—O Severe pain (10)

Are your symptoms affecting other areas of the body (e.g. legs, arms)? _____

How would you describe your symptoms? □ Numb □ Tingling □ Stiff □ Aching □ Throbbing □ Sharp □ Stabbing □ Burning

□ Shooting □ Cramps □ Nagging □ Other (please describe) _____

Have you had recent office visits with other providers for this condition? □ Yes □ No If yes, explain: _____

_____

What else have you done to try and reduce your symptoms? _____

Is there anything else we should know about your condition? _____

UPDATED MEDICAL HISTORY

Please list any recent surgeries/procedures: _____

Do you currently have, or have been diagnosed with, any of the following:

□ Frequent dizziness	□ Hypertension/High BP	□ Numbness/tingling	□ Other, please specify:
□ Headaches or Migraines	□ Heart attacks/Stroke	□ Fatigue/Weakness	_____
□ Head injuries/Whiplash	□ Nausea/Vomiting	□ Excessive weight gain/loss	_____
□ Eye/Vision Problems	□ Constipation	□ Kidney Stones	_____
□ Ear/Hearing Problems	□ Back/neck pain	□ UTIs	
□ Trouble Breathing	□ Arthritis	□ Cancer, *Type:* _____	

Please list all medications you are currently taking, with dosage and frequency, if known. Use reverse side if needed.

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

Do you have any medical allergies? _____

Are you aware of any hereditary issues? _____

UPDATED SOCIAL HISTORY

Do you drink alcohol? □ Yes □ No If yes, how much on average? _____

Do you drink coffee? □ Yes □ No If yes, how much on average? _____

Do you use tobacco products? □ Yes □ No If yes, how much? _____

Do you exercise? □ Yes □ No If yes, explain: _____

Do you take pain relievers? □ Yes □ No If yes, explain: _____

Do you drink soft drinks? □ Yes □ No If yes, how much on average? _____

Do you drink water? □ Yes □ No If yes, how much on average? _____

ACKNOWLEDGEMENTS AND INFORMED CONSENT

I instruct the chiropractic physician and other providers 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 office is based on the best available evidence and designed to reduce my symptoms. I also understand that any risks, contraindications, or alternative treatments for my condition will be discussed with me during my treatment. Although extremely rare, complications can include fractures, disc injuries, dislocations, and/or muscle strains. Some types of neck manipulation have been associated with injuries to arteries in the neck leading to stroke. This is heavily debated and studies show that this occurs between one in one million and one in five million cervical adjustments. Muscle soreness or stiffness is common, especially after your first appointment. Please discuss any alarming side effects with the doctor/providers if you experience any. Treatment will include a comprehensive exam and review of your medical history, imaging studies (if recommended), therapeutic modalities (e.g. muscle stimulation, decompression, dry needling), and the chiropractic manipulation. Finally, I ensure that, 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.

Signature: _____ **Today's 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 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.

_____ _____

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