WELCOME!

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

Section A – Personal information

Today's Date _____ **Referred to us by anyone? _____**

Your Name (first/middle/last) _____ Birth Date _____

Your Address _____

Primary/Cell Phone # _____ Cell Carrier (for appt reminders, e.g. Verizon) _____

Email Address _____ Check here if you'd prefer email appointment reminders ☐

Are you married, single? _____ Spouse's Name _____

What is your gender identity? _____ Social Security # _____

Employer Name _____ Occupation _____

Employer Address _____

Employer Phone # _____ May we call you at work? _____

Do you have a primary care physician? _____ Their name? _____

Section B - Insurance information

if you have supplied a copy of your insurance card(s) to office staff, you may skip to Section C

Insurance Carrier _____ Policy # _____ Group # _____

Primary Insured's Name _____ Relation to Insured (if not self) _____

Do you have a secondary insurance? _____

If so, please list that information here _____

Section C – Important Financial Acknowledgements

please read and acknowledge (initial) each and sign

_____ 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.

_____ I acknowledge a **$25.00 no-show fee** for missed appointments. We understand certain circumstances may arise and this fee can be waived at the staff's discretion. We appreciate at least a 24 hours' notice for all canceled and rescheduled appointments.

Signature: _____ Today's Date: _____

CHIROPRACTIC and MEDICAL 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 10
Absent Uncomfortable Severe

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

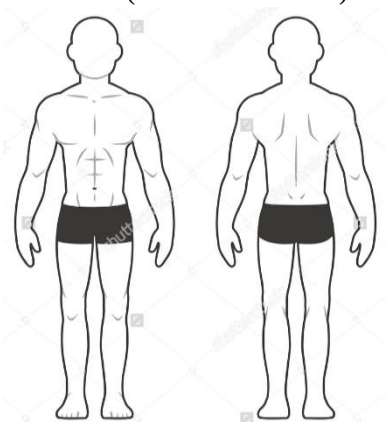
O Constant O Comes and goes. How often? _____

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? _____

Have you consulted a chiropractor before? _____**If so, whom and when?** _____

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? _____

CHIROPRACTIC and MEDICAL QUESTIONNAIRE (cont.)

Medical History

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

Review of Systems (please answer yes/no to the following questions)

Are you currently experiencing or do you frequently experience chills/fevers? O YES O NO

Have you experienced unexplained weight gain or weight loss? O YES O NO If yes, which? _____

Do you experience frequent bouts of dizziness, frequent bouts of fainting, or frequent/debilitating headaches? O YES O NO

Have you ever experienced a concussion or severe head injury? O YES O NO If yes, when and how? _____

Do you experience vision issues, other than those corrected by glasses/contacts? O YES O NO If yes, what? _____

Do you experience or have you experienced a prolonged ringing sound in your ears? O YES O NO

Frequent ear infections/ear pain? O YES O NO Do you wear or need hearing aids? O YES O NO

Do you experience shortness of breath, or do you have Asthma? O YES O NO Inhaler? O YES O NO

Have you been diagnosed with hypertension (high blood pressure)? O YES O NO On medication for it? O YES O NO

Have you ever experienced a heart attack or stroke, or do you have concerns of heart palpitations? O YES O NO

Do you have frequent abdominal pain, nausea/vomiting, diarrhea, or constipation? O YES O NO

Have you been diagnosed with arthritis? O YES O NO If so, where? _____

Would you say you have frequent and prolonged back/neck pain, restricted motion, muscle spasms, or joint pain? O YES O NO

Have you been diagnosed with an anxiety or depression disorder? O YES O NO On medication? O YES O NO

Do you have a diagnosed skin condition? O YES O NO Do you bruise easily? O YES O NO

Do you experience frequent and/or prolonged numbness/tingling sensations in areas of your body (legs, arms, etc)? O YES O NO

Do you have chronic fatigue? O YES O NO

Do you have a high frequency or pain/blood with urination? O YES O NO Frequent kidney stones/UTIs? O YES O NO

Do you drink coffee daily? O YES O NO Do you drink alcohol regularly? O YES O NO Tobacco use? O YES O NO

Do you exercise regularly? O YES O NO Do you take pain relievers? O YES O NO Good water intake? O YES O NO

Do you have any known medical allergies? O YES O NO Please list: _____

Please list any other pertinent medical information you'd like to provide for the doctor below, including known family history:

_____

Surgeries/Operations/Imaging

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: _____

Have you ever had an X-ray or MRI of your spine? O YES O NO If yes, when/where? _____

Medications

Medication/Vitamin Name	Dosage	Frequency	Medication/Vitamin Name	Dosage	Frequency
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		
11.			12.		
13.			14.		
15.			16.		

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

Acknowledgements, Informed Consent of Treatments, HIPAA Authorizations

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 $20-60 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

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.

_____ initial

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.

Please list names/relationships of people you authorize to have PHI released: _____

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

Signature: _____ Today's Date: _____