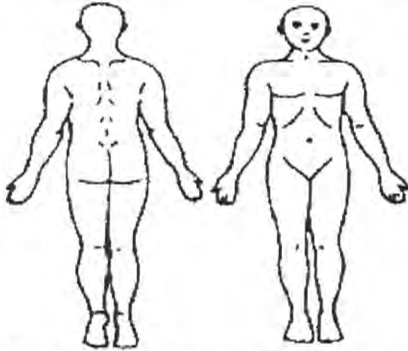
Welcome to Total Wellness Chiropractic Center. So that we may provide you with the best possible care, please take a moment to fully complete the following information. Thank you.

Patient Information		
Last Name:	**First Name**:	**Middle Initial**:
Gender: Male Female	**Marital Status**: Married Single Divorced Widowed	
Mailing Address:		
City:	**State**:	**Zip**:
Date of Birth:		
Social Security Number:		
Work Phone:	**Cell:**	**Home:**
E-Mail:		
Primary Care Physician:		
Employer:	**Number hours per week:**	
How did you hear about us?		
Who is responsible for your bill?	Self Worker's Comp Auto Insurance Medicare Medicaid Health Insurance:	
Emergency Contact and #:		

Current Health Conditions	
Health related problem you are having today:	
Other Doctors seen for this condition:	
Type of treatment:	**Results**:
Onset Date:	**Has this condition occurred before**: Yes No
Is condition: Job Related Auto Accident Home Injury Fall Other	
Date of accident:	
Have you made a report of your accident with your employer? Yes No	
Current Medications:	
Do you wear a shoe lift? Yes No	
Do you suffer from any condition other than that which you are now consulting us?	
Major surgery/operations:	
Other Hospitalizations:	
Major accidents or falls:	
Previous Chiropractic Care: None	Doctor's Name and approx. date of last visit:
What would you like to achieve from Chiropractic Care?	

Below is a list of diseases that may seem unrelated to the purpose of your appointment today but must be answered carefully as these problems can affect your overall course of care.



Please mark your area of pain above.

Please check the following diseases you have had:

- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Lumbago
- ☐ Eczema
- ☐ Arthritis
- ☐ HIV
- ☐ Mental Disorders
- ☐ Stroke/Heart Attack

Intake:

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

Check any of the following you have or have had in the past:

Musculo-Skeletal

- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Difficulty Walking
- ☐ Clicking Jaw
- ☐ TMJ
- ☐ Heartburn
- ☐ Gas/Bloating
- ☐ Black/Bloody Stool
- ☐ Colitis

Genitio-Urinary

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

Nervous System

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

C-V-R

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

General

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

EENT

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

Gastro-Intestinal

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea/ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Gender Specific

Female

- ☐ Menstrual Irregularity

Date of last period?: ____________

Are you pregnant?: ____________

- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Other____________

Male

- ☐ Prostate
- ☐ Sexual Dysfunction
- ☐ Other____________

Do you have or have you had? ☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Stiffness ☐ Tingling ☐ Numbness ☐ Muscle Spasm ☐ Headache

Of the above, what is the worst? ____

Family History

The following family members have the same or similar problems as I do:

____

Patient Signature:____ **Date:**

CHIROPRACTIC HISTORY

Patient Name: ____________________ Initial Exam: ___/___/___

CHIEF COMPLAINT(S):
#1 Complaint: ____________________
#2 Complaint: ____________________
#3 Complaint: ____________________
#4 Complaint: ____________________

ONSET:
Please Explain
When did the pain start? ____________________
❑ Specific Injury ❑ Over Time? ____________________

What makes the pain worse? ____________________

What makes the pain better? ____________________

DO YOU FEEL LIKE THIS CONDITION IS GETTING WORSE?
❑ Yes ❑ No ❑ Unsure

HAVE YOU HAD SIMILAR COMPLAINTS BEFORE?
❑ Yes ❑ No ❑ Unsure

QUALITY:
What does the pain feel like?

❑ Sharp ❑ Dull ❑ Burns ❑ Shooting ❑ Crushing ❑ Throbbing ❑ Achy ❑ Stiff ❑ Numb
❑ Tingling

Other: ____________________

RADIATION:
Does the pain move or radiate? ❑ Yes ❑ No

If yes, describe: ____________________

RESTRICTIONS:
Does the pain stop you from or reduce your ability to do any of your normal activities?
❑ Yes ❑ No
If yes, describe: ❑ Sleep ❑ Work ❑ Recreation ❑ Daily Routine

SEVERITY
(1-10 with 10 being worst) Now ____ Average ____ Best ____ Worst ____

Have you had any conditions in the past that left you with ongoing problems?

❑ Yes ❑ No

If yes, describe: ____

____

TIMING

Is the pain:

❑ Constant ❑ Intermittent

❑ Better in am ❑ Worse in am

❑ Better in pm ❑ Worse in pm

Has this pain ever occurred before? ❑ Yes ❑ No. If yes, when? ____________________

 # OF TIMES PER WEEK YOU HAVE THIS PROBLEM?

❑ Every day ❑ ____

PREVIOUS TREATMENT(S) FOR THIS CONDITION:

❑ OTC Meds ❑ Rx Meds ❑ Chiropractic ❑ Physical Therapy ❑ Ice ❑ Heat

❑ Exercise ❑ Rest

❑ Others ____

PREVIOUS SURGERIES:

____

____

____

OTHER COMPLAINTS:

____

____

____

NOTES:

____

____

____

Patient Signature: ______________________________ Date: ___/___/___

Dr Signature: ______________________________ Date: ___/___/___

Authorizations and Release

Name: ______________________________

Consent of Treatment

I, the undersigned , hereby authorize Dr. Richard Kappes and whomever he may designate as his assistant(s) to perform diagnostic tests and administer treatment as necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature ______________________________ Date___/___/___ Witness Initials__________

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I authorize the doctor to release any information necessary to my Primary Care Provider in order to coordinate care.

Patient's Signature ______________________________ Date___/___/___ Witness Initials__________

Request for Payment of Benefits to Provider of Care

I hereby authorize the ____________________________ Insurance Company/Insurance Administrator to pay by check, and for it to be directly mailed to: Total Wellness Chiropractic Center the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said charges. I agree that this office be given my permission to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature ______________________________ Date___/___/___ Witness Initials__________

Consent for Treatment of a Minor

I hereby authorize Dr. Richard Kappes and whomever he may designate as his assistant to perform diagnostic tests and to administer treatment as he deems necessary to my (indicate relationship to child)___________________(child's name)______________________________.

Legal Guardian's Signature ________________________ Date___/___/___ Witness Initials__________

Verification of Non-Pregnancy (Female Patients Only)

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period__________________.

Patient's Signature ______________________________ Date___/___/___ Witness Initials__________

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining you consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Office Manager: Tina Kappes Phone: 301-352-3454

I acknowledge that I have read and understand this Notice of Information Practices.

_______________________________ _______________________

Signature of Patient Date