

Welcome to Wayda Go! Chiropractic

PERSONAL INFORMATION:

Date _____
Name _____
Address _____
City, State, Zip Code _____
Date of Birth _____
Social Security # _____
Home Phone _____
Work Phone _____
Cellular Phone/Beeper _____
Email Address _____
Sex _____ M or F Martial Status _____ M, S, D, W, Sep. Occupation _____
Employer (Name and City) _____
How did you find out about our office? _____

CONTACT INFORMATION:

Where do you prefer to receive calls? ____ Home ____ Work ____ Cell Phone _____
When is the best time to reach you? Time _____ Days _____
In case of emergency, who should we contact?
Name _____ Relationship _____ Home # _____ Work # _____

INSURANCE INFORMATION:

Primary Insurance	Additional Insurance
Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured’s Birthdate _____	Insured’s Birthdate _____
Insured’s SS # _____	Insured’s SS # _____
Insured’s Employer _____	Insured’s Employer _____
Insured’s Occupation _____	Insured’s Occupation _____
Insurance Company _____	Insurance Company _____
Ins. Co. Phone # _____	Ins. Co. Phone # _____
Group # _____	Group # _____

I understand that my insurance is a contract between myself and my insurance company. While I understand it is the policy of this office to file my insurance claims for me, as a service to me, I agree to be responsible for payment of all services rendered on my behalf for my dependents.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

X _____
Signature of patient (or parent if minor)

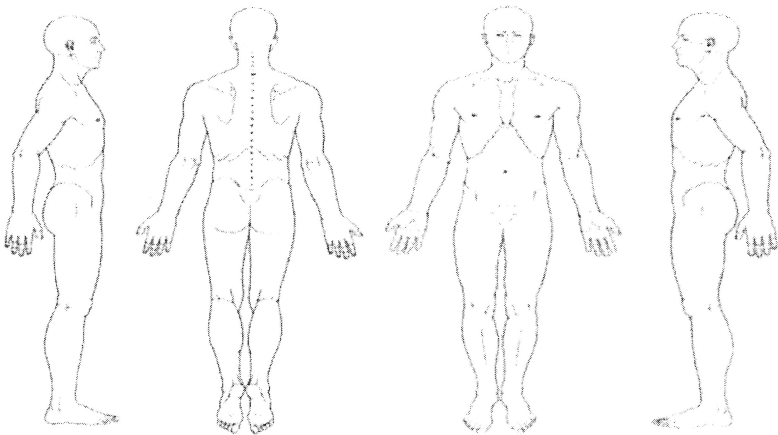
Patient Name

Date

1. Describe your symptoms
-
-
- a. When did your symptoms start?
-
- b. How did your symptoms begin?
-

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

- a. Indicate the average intensity of your symptoms
- None
- ①
- ②
- ③
- ④
- ⑤
- ⑥
- ⑦
- ⑧
- ⑨
- ⑩
- Unbearable
- b. How much has pain interfered with your normal work (including both work outside the home, and housework)
- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

- (like visiting with friends, relatives, etc)
- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

- a. What treatment did you receive and when?
-
- b. What tests have you had for your symptoms and when were they performed?
- ① Xrays date:
- ② MRI date:
- ③ CT Scan date:
- ④ Other date:

9. Have you had similar symptoms in the past?

- a. If you have received treatment in the past for the same or similar symptoms, who did you see?
- ① Yes
- ② No
- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

-
- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other
- a. If you are not retired, a homemaker, or a student, what is your current work status?
- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature

Date

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ Date _____

What type of regular exercise do you perform?

① None

② Light

③ Moderate

④ Strenuous

What is your height and weight?

Height

<i>Feet</i>	<i>Inches</i>

Weight

--	--	--

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past Present

- ☐ ☐ Headaches
- ☐ ☐ Neck Pain
- ☐ ☐ Upper Back Pain
- ☐ ☐ Mid Back Pain
- ☐ ☐ Low Back Pain
-
- ☐ ☐ Shoulder Pain
- ☐ ☐ Elbow/Upper Arm Pain
- ☐ ☐ Wrist Pain
- ☐ ☐ Hand Pain
-
- ☐ ☐ Hip/Upper Leg Pain
- ☐ ☐ Knee/Lower Leg Pain
- ☐ ☐ Ankle/Foot Pain
-
- ☐ ☐ Jaw Pain
-
- ☐ ☐ Joint Swelling/Stiffness
- ☐ ☐ Arthritis
- ☐ ☐ Rheumatoid Arthritis
-
- ☐ ☐ General Fatigue
- ☐ ☐ Muscular Incoordination
- ☐ ☐ Visual Disturbances
- ☐ ☐ Dizziness

Past Present

- ☐ ○ High Blood Pressure
- ☐ ○ Heart Attack
- ☐ ○ Chest Pains
- ☐ ○ Stroke
- ☐ ○ Angina
- ☐ ○ Kidney Stones
- ☐ ○ Kidney Disorders
- ☐ ○ Bladder Infection
- ☐ ○ Painful Urination
- ☐ ○ Loss of Bladder Control
- ☐ ○ Prostate Problems
- ☐ ○ Abnormal Weight Gain/Loss
- ☐ ○ Loss of Appetite
- ☐ ○ Abdominal Pain
- ☐ ○ Ulcer
- ☐ ○ Hepatitis
- ☐ ○ Liver/Gall Bladder Disorder
- ☐ ○ Cancer
- ☐ ○ Tumor
- ☐ ○ Asthma
- ☐ ○ Chronic Sinusitis

Past Present

- ☐ ☐ Diabetes
- ☐ ☐ Excessive Thirst
- ☐ ☐ Frequent Urination
- ☐ ☐ Smoking/Use Tobacco Products
- ☐ ☐ Drug/Alcohol Dependence
- ☐ ☐ Allergies
- ☐ ☐ Depression
- ☐ ☐ Systemic Lupus
- ☐ ☐ Epilepsy
- ☐ ☐ Dermatitis/Eczema/Rash
- ☐ ☐ HIV/AIDS

Females Only

- ☐ ☐ Birth Control Pills
- ☐ ☐ Hormonal Replacement
- ☐ ☐ Pregnancy
- ☐ ☐

Other Health Problems/Issues



Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Wayda Go! Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wayda Go! Chiropractic. I understand that diagnosis or treatment of me by Wayda Go! Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wayda Go! Chiropractic is not required to agree to the restrictions that I may request. However, if Wayda Go! Chiropractic agrees to a restriction that I request, the restriction is binding on Wayda Go! Chiropractic and Dr. Jeffery D. Wayda.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Jeffery D. Wayda or Wayda Go! Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wayda Go! Chiropractic's Notice of Privacy Practices prior to signing this document. The Wayda Go! Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wayda Go! Chiropractic. The Notice of Privacy Practices for Wayda Go! Chiropractic is also provided in the magazine rack in a folder marked Notice of Privacy Practices. This Notice of Privacy Practices also describes my rights and Wayda Go! Chiropractic's duties with respect to my protected health information.

Wayda Go! Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority