5395 Estate Office Dr. #2 Memphis TN 38119 (901) 672-7308

Name_____Date_____

Address_____City_____St_____Zip_____

Phone Number_____E-mail _____

Phone Provider (for appt. reminders) _____

Date of Birth_____Age:_____Sex: ( ) Male ( ) Female Number of Children_____

Employer_____Occupation_____

Marital Status (circle one) M S D W Spouse's Name_____

How did you hear about us?_____

Have you ever had chiropractic care before? Y N Date_____

Insurance Information

Primary Insurance Company_____

* We will make a copy of your insurance card.

Social Security Number_____(for insurance filing)

==========

Mark next to your CURRENT problem(s).

( ) Headache ( ) Neck Pain ( ) Mid Back Pain ( ) Low Back Pain ( ) Other_____

Date problem began_____

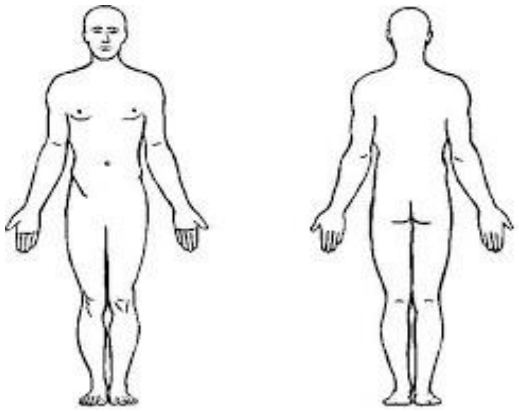
How problem began_____

Is this auto related? YES or NO

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

Circle all of the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Unbearable	Miserable	Exhausting
Stabbing	Tiring	Gnawing



Please mark an **X** on the picture where you have pain or other symptoms.

Circle the number that best describes your pain RIGHT NOW.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable.

What makes your pain <u>BETTER?</u>_____

What makes your pain <u>WORSE?</u>_____

How often are your symptoms present?

(Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

Please list ALL MEDICATIONS you are currently taking.

_____

Please list any surgeries you have had.

_____

Check any of the following you have had in the last six months:

( ) Headaches	( ) Blood Pressure Problems	( ) Constipation/ Diarrhea
( ) Sinus Congestion / Allergies	( ) Ankle Swelling	( ) Discolored Urine
( ) Vision Problems	( ) Prostate/ Sexual Dysfunction	( ) Poor / Excessive Appetite
( ) Earaches	( ) Menstrual Cycle Dysfunction	( ) Excessive Thirst
( ) Dizziness	( ) Numbness	( ) Painful/ Excessive Urination
( ) Heart Problems	( ) Frequent Nausea/ Vomiting	( ) Cancer
( ) Lung Problems	( ) Abdominal Cramps	( ) Diabetes

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PHI is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Patient/ Guardian Signature_____Date_____

Informed Consent

Patient Name _____

Whole Health Chiropractic and Wellness Center

Dr. Benjamin Boston

5393 Estate Office Dr. Memphis, TN 38119

Phone: (901) 672-7308 Fax: (901) 672-7327

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or “Spinal Adjustment”. As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence, I will take precautions. These precautions include, but are not limited to, my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Date: _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent needs only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to ensure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date