Wilson Family Chiropractic

Dr. Katie Wilson & Dr. Jeffrey Goldwasser
73 West Main Street Sylva, NC 28779
Phone: 828-587-CARE (2273) Fax: 828-587-2274

PERSONAL HISTORY

Date: _____

Who is responsible for your bill? ❑Auto insurance ❑Personal Health insurance ❑Self (Uninsured) ❑Other _____

(Please Note: Payment is expected at the time services are rendered unless other arrangements have been made with our office prior to your visit)

PERSONAL INFORMATION

Preferred Name: _____ **Date of Birth:** ____/____/_____ **Age:** _____ **Gender:** ❑Male ❑Female ❑Unspecified

First Name: _____ **Middle Name:** _____ **Last Name:** _____ **Suffix:** _____

Local Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____ **Email Address:** _____

(By providing my email address, I authorize my doctor to contact me via email)

Appointment Reminder Method: ❑Text (Cell Phone Provider _____) ❑Email (Please list above)

* Please note, reminder calls/texts/emails are a courtesy. You are responsible for your appointment whether your reminder was received or not

How did you hear about us or, who referred you? _____

Marital Status: ❑Single ❑Widowed ❑Married **Spouse / Partner Name:** _____ **Number of Children:** ____

Employment Status: ❑Employed ❑FT Student ❑PT Student ❑Retired ❑Self-Employed ❑Other _____

Employer and /or Type of Work _____

Race: ❑White ❑Asian ❑Japanese ❑Samoan ❑Black/African American ❑Asian Indian ❑Korean ❑Chinese ❑Vietnamese

❑Guamanian or Chamorro Hispanic American Indian/Alaskan Native ❑Filipino ❑Native Hawaiian or other Pacific Island

❑Other _____ ❑I choose not to specify / **Multi-Racial:** ❑Yes ❑No ❑Unknown

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑I chose not to specify **Preferred Language:** ❑English ❑Other _____

HEALTH HISTORY

Purpose of this Appointment: _____ **Other Doctors seen for this condition:** _____

When did this condition begin: _____ Is it: ❑Job related ❑Auto related ❑Home accident

Major Surgery/Operations: ❑Appendectomy ❑Cancer related ❑Gall Bladder ❑Hernia ❑Spinal ❑Hysterectomy ❑Broken Bones ❑Other: _____ **Hospitalizations** (other than above): _____

Accidents/Falls History (such as auto/work/sport-related/jolts/trauma/etc.): ***IMPORTANT INFORMATION...***

All events which could have any impact upon the spine are of high significance to determine spinal health history. Please fill out completely.

Within the past year – when/describe: _____ **Over a year ago –** when/describe: _____

Childhood – when/describe: _____ **Previous Chiropractic Care:** ❑No ❑Yes: where/when _____

_____

Women only: Are you pregnant? _Yes _No

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ (Approximately) _____ Signature _____ Date

Do you currently use tobacco of any kind? ❑Yes ❑Former Smoker ❑Never been a Smoker

If yes, how often: ❑Currently everyday smoker/user ❑Current smoker/user sometimes

Interested in quitting? ❑ 0 *(No Interest)* ❑ 5 *(Somewhat Interested)* ❑ 10 *(Very Interested)*

Height _____ Weight _____

Blood Pressure _____ Pulse _____

MEDICATIONS

List your Current Medications:

Medication	Dosage	Frequency

List Medical Allergies:

Medication Allergy	Reaction	Date Began

If there are no current medications, check here: ____

If there are no allergies known, check here: ____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ❑Yes ❑No ***If yes***, when? _____

Has any doctor diagnosed you with Diabetes presently? ❑Yes ❑No ***If yes,*** what kind? ❑Type I ❑Type II

If yes to Diabetes, was your hemoglobin A1C>9.0%? ❑Yes ❑No ❑Unsure **May we obtain a copy of your A1C?** ❑Yes ❑No

Have you had an X-ray, CT scan or MRI of your spine in the past 28 days? ❑Yes ❑No ***If yes,*** Where? _____

Do you purchase any Vitamins or Health Food Products? ❑No ❑Yes **Exercise regularly? :** ❑No ❑Yes-**how often?** ____/ week

We offer advice on nutritional supplementation, weight loss, & detox, Are you interested in learning more? ❑No ❑Yes

Please check <u>any</u> of the following that give you difficulty or you have had recently.

General
- ❑Headaches
- ❑Shooting head pain
- ❑Loss of memory
- ❑Fatigue
- ❑Depression
- ❑Dizziness
- ❑Thyroid trouble
- ❑Sleeping problems
- ❑Seizures
- ❑Fainting
- ❑Irritability
- ❑Stress
- ❑Weight gain
- ❑Weight loss
- ❑Facial pain / Twitch
- ❑Jaw pain (TMJ)
- ❑Menstrual cramps/pain
- ❑Menstrual irregularity
- ❑Loss of balance
- ❑Prostate trouble
- ❑Hernia
- ❑Arthritis
- ❑Ulcers

Skin
- ❑Bruise easily
- ❑Hives
- ❑Itching/Rash
- ❑Sores that won't heal

Gastrointestinal
- ❑Bowel changes
- ❑Intestinal gas
- ❑Constipation
- ❑Indigestion
- ❑Nausea
- ❑Stomach issues
- ❑Vomiting
- ❑Gall bladder trouble

Arms & Hands
- ❑Pins & needles in arms/Hands
- ❑Numbness in arms/hands
- ❑Pain in upper arm
- ❑Pain in elbow
- ❑Pain in forearm
- ❑Pain in hand/fingers
- ❑Weakness of hand
- ❑Cold hands

Eye/Ear/Nose & Throat
- ❑Sinus trouble/Allergies
- ❑Loss of smell
- ❑Hay fever
- ❑Asthma
- ❑Loss of taste
- ❑Inflammation of throat
- ❑Earache
- ❑Hoarseness
- ❑Loss of hearing
- ❑Persistent cough
- ❑Ringing in ears
- ❑Blurred vision
- ❑Vision-flashes/halos
- ❑Tonsillitis
- ❑Lights bother eyes

Neck
- ❑Neck pain/Stiffness
- ❑Grinding/popping in neck
- ❑Pinched nerve in neck
- ❑Neck feels out of place
- ❑Muscle spasms in neck

Shoulders
- ❑Shoulder/arm tightness
- ❑Shoulder/arm pain
- ❑Pain in shoulder joint
- ❑Pain across shoulders
- ❑Can't raise arms
- ❑Tension in shoulders
- ❑Pinched nerve in shoulders

Cardiovascular
- ❑Chest pain
- ❑Heart attacks
- ❑Stroke
- ❑High blood pressure
- ❑Poor circulation
- ❑Irregular heart beat
- ❑Rapid heart beat
- ❑Swollen ankles
- ❑Cold feet
- ❑Anemia

Mid Back
- ❑Mid-back pain/Stiffness
- ❑Spinal curvature
- ❑Pain between shoulder blades
- ❑Muscle spasms in Mid–Back

Low Back
- ❑Low back pain/Stiffness
- ❑Low back weakness
- ❑Low back feels out of place
- ❑Muscle spasms in low back

Hips, Legs & Feet
- ❑Cold feet
- ❑Pain in buttocks
- ❑Pain in hip joint
- ❑Pain down leg
- ❑Pain in knee
- ❑Pain in ankle
- ❑Pain in foot
- ❑Weakness of leg
- ❑Weakness of knee
- ❑Leg cramps
- ❑Pins & needles in legs
- ❑Numbness in legs/feet

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

(If under age 18)Parent's Signature _____ Date _____

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. This Notice describes the use and disclosure of my Protected Health Information (PHI) that will occur during the extent of my treatment at this office. This Notice of Privacy Practices also describes my rights and the duties of the Chiropractor with respect to my protected health information. I hereby give permission to Wilson Family Chiropractic (WFC) to use/disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- ❑ I give permission to WFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday cards, newsletters, information about treatment alternatives or other health information.
- ❑ If WFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ❑ I give WFC permission to treat me in an open room where other patients in the office may overhear some of my protected health information during the course of care. If I need to speak with the doctor privately, a room will be provided.

The use of this format is intended to make your experience with our office more efficient as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Wilson Family Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this authorization in at any time. However, your request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mail or hand delivering a written notice to the Privacy Official of WFC (The revocation is not effective until it is received by the Privacy Official). The written notice must contain the following information:

- Your name, Social Security number and date of birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your Signature

This Authorization is requested by WFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)* I have the right to refuse to sign this Authorization. If I refuse to sign this Authorization, WFC will not refuse to provide treatment however, it will not be possible to file insurance on my behalf and I will be responsible for payment in full at the time services are provided to me. I have the right to inspect/copy (within reason) the protected health information to be used/disclosed. (A copy fee will apply)

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

My name (please print): _____ My Signature: _____

Patient or Parent Guardian

WILSON FAMILY CHIROPRACTIC: Terms of Acceptance

When a patient seeks chiropractic health care with us, it is essential for both parties to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment:	**Health:**	**Vertebral Subluxation:**
An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Out chiropractic method or correction is by specific adjustment of the spine.	A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.	A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

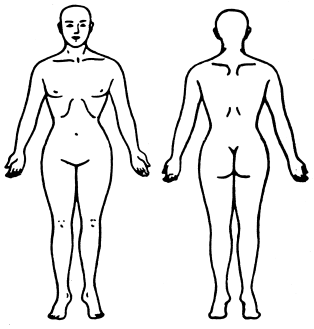
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnoses or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

By Signing below I agree that I have read and fully understand the above statements. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date:_____

Patient or Parent/Guardian

MASSAGE THERAPY



Please indicate with an (X), if any, the areas in which you are feeling discomfort

JUST SO WE KNOW...

Do you have any allergies? (i.e. skin care products, fragrances, oils, foods, etc)_____

_____

Type of massage experienced (Swedish, shiatsu, deep tissue, etc.) _____

_____

Do you have a preference on massage pressure? __ Light Touch __Firm Touch __Deep Pressure

Additional Information:_____

_____

_____

CLIENT RELEASE FOR MASSAGE THERAPY

(Please read & sign even if you are not scheduled for a massage at this time)

- ◊ I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension.
- ◊ If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
- ◊ I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.
- ◊ I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- ◊ Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.
- ◊ I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
- ◊ I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
- ◊ If late for my scheduled appointment, I understand those minutes will be deducted from my session and I will still pay for the full visit.
- ◊ **We ask for a 24 hour notice if you are not able to make your appointment. If you fail to cancel in a timely manner and/or do not show up to your appointment you will incur a $25.00 service fee.** ⇨ Initial here _____

By Printing, signing, & dating below you are indicating you have read & accept our client release for massage therapy.

Client Name (Printed): _____ Client Signature: _____ Date: _____

Patient or Parent/Guardian

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings &/or expression movement of intestinal gas, energy shifts, falling asleep & memories.