LIVING WELL
:health & wellness center:

Chiropractic Welcome - New Patient Registration

Please ask if you need assistance completing this paperwork. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

DATE

1 PATIENT CONTACT

Last Name	First Name	
Preferred to be called		
Street		
City	State	Zip Code
Home Phone	Mobile Phone	
Work Phone	E-mail	

2 PERSONAL INFORMATION

Age	Date of Birth	Social Security #	Gender ○ Male ○ Female
Status ○ Single ○ Married ○ Partnered ○ Widowed ○ Separated			

3 EMERGENCY CONTACT

Name	Home Phone
Relationship	Mobile Phone

4 SPOUSE OR GUARDIAN

Last Name	First Name	
Employer Name		
Work Phone	Date of Birth	Social Security #

5 PATIENT EMPLOYMENT

Employer Name	Occupation	
Street		
City	State	Zip Code

Which one of our patients referred you or how did you hear about our clinic?

During the first office visit we will conduct a thorough history, consultation, and preliminary screening. If we believe we will be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to the type of care we offer, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

PATIENT OR GUARDIAN SIGNATURE

DATE

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Patient Case History

Please ask if you need assistance completing this paperwork. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

DATE

1 PATIENT INFORMATION

Last Name	First Name	M.I.

2 HEALTH COMPLAINT

Are you here because you were injured while working, in a motor vehicle collision or in another accident? ○ **Yes** ○ **No**

What services interest you? (mark all that apply)

- ○ injury prevention
- ○ balance and coordination training
- ○ range of motion, mobility, or flexibility therapy
- ○ treatment for pain
- ○ sports injury/rehabilitation
- ○ nutritional consult
- ○ chiropractic
- ○ patient education classes
- ○ detox EB Pro Footbath
- ○ Other: _____

What is your **primary** health complaint?

How long have you been experiencing this **primary** health complaint?

How does the **primary** complaint feel? ○ dull/achy ○ sharp ○ numb ○ tingling ○ burning ○ cold

How often do you experience the **primary** health complaint? ○ constantly ○ daily ○ weekly ○ monthly ○ yearly

Using the scale below, rate how your the **primary** complaint affects your life (mark all that apply)

1. no pain or discomfort	2. slight discomfort	3. pain that does not affect my activity	4. pain that affects my daily activity	5. pain that prevents performing my daily activity	6. pain that limits my work schedule	7. pain that prevents working at al	8. pain that prevents working and all personal activity	9. pain that keeps me bed riddent	10. pain that causes thoughts of suicide

If you have missed work becasue of your **primary** complaint, when was your last work day?

What do you believe is the cause of your **primary** complaint?

List other health complaints (2-5) on the following lines:

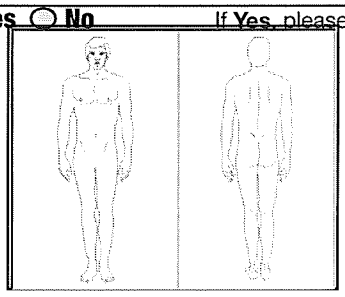
2._____ 4._____

3._____ 5._____

Do you have other conditions than what brings you here? ○ **Yes** ○ **No** If **Yes**, please list here:

Please mark the areas of all of your complaints on the diagram. Include any descriptions or comments, concerning your health conplaints that are not reflected above.

N = Numbness
T = Tingling
P = Pain
W = Weakness



Patient Case History (cont.)

patient name

3 LIFESTYLE & HABITS

How many hours of television do you watch a day? ○ <1 ○ 1-3 ○ 3-5 ○ >5

Do you usually snack while watching television? ○ yes ○ no

How many hours do you use a computer at work and at home? ○ <1 ○ 1-3 ○ 3-5 ○ >5

How often do you **excercise**? ○ daily ○ 3-4 x's/week ○ 2x's/week ○ 1x/week ○ I don't exercise

How long do your **exercise** workouts last? ○ >1hour ○ <1 hour ○ 30 minutes ○ <30 minutes ○ NA

What are your **exercise** activities? (mark all that apply) ○ I don't exercise

- ○ walking
- ○ swimming
- ○ running/treadmill/eliptical/stair climbing
- ○ stretching/flexibility
- ○ chiropractic
- ○ weight training
- ○ group exercise classes
- ○ yoga/pilates
- ○ resistance bands
- ○ Other: _____

Do you take a multi-vitamin? ○ yes ○ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking, and the reason:

1._____ 3._____

2._____ 4._____

Have you ever used tobacco? ○ never ○ daily ○ weekly ○ monthly ○ yearly

How many servings of alcohol do you drink each week? ○ 0 ○ 1-2 ○ 3-5 ○ >5

How many servings of coffee do you drink each week? ○ 0 ○ 1-2 ○ 3-5 ○ >5

How many servings of soda do you drink each week? ○ 0 ○ 1-2 ○ 3-5 ○ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. **N**=never **P**=previously **C**=currently

diabetes	N P C mother	N P C father	N P C brother	N P C sister
heart problems	N P C mother	N P C father	N P C brother	N P C sister
kidney problems	N P C mother	N P C father	N P C brother	N P C sister
cancer	N P C mother	N P C father	N P C brother	N P C sister
headaches	N P C mother	N P C father	N P C brother	N P C sister
back pain	N P C mother	N P C father	N P C brother	N P C sister
obesity	N P C mother	N P C father	N P C brother	N P C sister
poor conditioning	N P C mother	N P C father	N P C brother	N P C sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	○ yes ○ no	goiter	○ yes ○ no	measles	○ yes ○ no	tuberculosis	○ yes ○ no
anemia	○ yes ○ no	heart disease	○ yes ○ no	mental disorders	○ yes ○ no	rheumatic fever	○ yes ○ no
anxiety	○ yes ○ no	HIV positive	○ yes ○ no	mumps	○ yes ○ no	v. infection	○ yes ○ no
arthritis	○ yes ○ no	influenza	○ yes ○ no	pleurisy	○ yes ○ no	whiplash	○ yes ○ no
cancer	○ yes ○ no	diabetes	○ yes ○ no	pneumonia	○ yes ○ no	wooping cough	○ yes ○ no
epilepsy	○ yes ○ no	low back pain	○ yes ○ no	polio	○ yes ○ no	other	○ yes ○ no

Patient Case History (cont.)

patient name

6 INJURIES

List any **auto collisions** you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1		
2		
3		

List any **job injury** that you experienced. Begin with the most recent.

type of job injury	type of treatment received	date of job inury
1		
2		
3		

List any **sports injury** that you experienced.. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1		
2		
3		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1		
2		
3		

7 HOSPITAL/MEDICINE

Have you had breast implant surgery? ○ yes ○ no

Have you had knee or hip replacement surgury? ○ yes ○ no

Do you have a pacemaker? ○ yes ○ no

Do you have any other implantable medical devices in your body? ○ yes ○ no

List any broken bones, fractures, or dislocations that you may have had.

List any perscription or over-the-counter medications you area currently taking (and the reason).

1. _____ 3. _____

2. _____ 4. _____

Mark all of the following procedures as they pertain to you.

vaccinations	○ yes ○ no	tubes in ears	○ yes ○ no	hernia surgery	○ yes ○ no	eating disorders	○ yes ○ no
tonsillectomy	○ yes ○ no	appendectomy	○ yes ○ no	thyroid surgery	○ yes ○ no	psychotherapy	○ yes ○ no
gall bladder	○ yes ○ no	female surgery	○ yes ○ no	stomach surgery	○ yes ○ no	concussion(s)	○ yes ○ no
back surgery	○ yes ○ no	male surgery	○ yes ○ no	dialysis	○ yes ○ no	lapse of memory	○ yes ○ no
cancer	○ yes ○ no	DETAILS:	_____	chemotherapy	○ yes ○ no	spinal tap/injection	○ yes ○ no
epilepsy	○ yes ○ no	sinus surgery	○ yes ○ no	radiation therapy	○ yes ○ no	fainting	○ yes ○ no

LIVING WELL

: health & wellness center :

CONSENT TO CHIROPRACTIC EXAMINATION AND DIAGNOSTIC PROCEDURES

I, _____, do hereby authorize this Chiropractic Clinic and its Doctors, associates, assistants, and interns to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Chiropractic Clinic, Doctors, associates, assistants, or interns may consider necessary or advisable in the course of my health care.

I understand and agree this Chiropractic Clinic, Doctors, associates, assistants, and interns have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctors of the Chiropractic Clinic can determine whether to accept me as a patient.

_____
Date

_____ _____
Printed Name of Witness Printed Name of Patient

_____ _____
Signature of Witness Signature of Patient

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LIVING WELL HEALTH & WELLNESS CHIROPRACTIC CLINIC

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of the Notice of Privacy Practices for this Chiropractic Clinic.

Name (Print): _____ Date: _____

Signed: _____

THIS NOTICE DESCRIBES HOW CHIRORPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Responsibilities
Our Chiropractic Clinic is required to maintain the privacy of your Health Information. This includes medical information about you that is collected during the course of your treatment, such as your symptoms, examination and test results, diagnoses, treatment, and a plan for future care. Information about care that you have received from other providers may also be included in the Chiropractic Clinic's medical record. Health Information also includes demographic information and payment information.
We are required by law to provide you with this Notice of Privacy Practices. This Notice describes how we use your Health Information at the Chiropractic Clinic, and disclose (share) it with others outside our offices as necessary. Our Chiropractic Clinic must abide by the terms of the Notice currently in effect. We reserve the right to change the terms of our Notice and to make the new Notice provisions effective for all Health Information that it maintains. We will have the most current Notice to patients at all times, as well as if and when there are any changes to the terms of our Notice.
Uses and Disclosures of your Health Information
The following are examples of the types of uses and disclosures of your Health Information that our Chiropractic Clinic is legally permitted to make, as necessary, without your specific authorization:

A. Uses and Disclosures of Health Information for Treatments, Payment and Operations
1. Treatment: Your Health Information may be used and disclosed by your chiropractor and this Chiropractic Clinic staff who are involved in your care and treatment. In addition, your chiropractor or a staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition. We believe this is critical to provide you the very best in health care and is necessary, given the complexities of various health conditions.
2. Payment: Our insurance and billing staff may use and disclose your Health Information, as needed, to obtain payment for health care services. We may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO or your employer, if they are potentially responsible for the payment of your services. We may disclose information to your insurance company or a third party payer in order to make sure your treatment is approved, to verify eligibility or coverage for insurance benefits, and to permit the payer to review services provided to you for medical necessity.
3. Operations: Your chiropractor and members of the staff may need to use your Health Information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
In addition, unless you ask us not to, we will contact you to remind you of your appointments with us. If you are not home to receive an appointment reminder, a message will be left on your answering machine. We may also provide you with information about treatment alternatives or other health-related benefits, products and services that may be beneficial to you, again, with the hopes of improving your health and welfare.

B. Other Permitted and Required Uses and Disclosures of your Health Information
Under Federal law, we are also permitted or required to use or disclose your Health Information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider;
2. If we provide health care services to you as an inmate;
3. If we provide health care services to you in an emergency;
4. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so;
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care;
6. For reasons of Public Health, for example, to report reactions to medications or problems with products, or that you have been exposed to a communicable disease;
7. In the course of any judicial or administrative proceeding in response to a legal order or other lawful process, including a subpoena;
8. For law enforcement purposes;
9. To a health oversight agency for audits, investigations, inspections, and other health oversight activities;
10. To comply with Workers' Compensation laws and other programs that provide benefits for work-related injuries.

Our Privacy Pledge
Our Chiropractic Clinic has always, and will always respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your Health Information to any outside marketing organization.
Your Individual Rights as a Patient
Although your medical records at our Chiropractic Clinic are the property of our Chiropractic Clinic, the Health Information your records contain belongs to you. The following are rights you have with respect to your Health Information, and a brief description as to how you may exercise these rights.

A. Your right to revoke your authorization
You may revoke your authorization to us at any time; however, your revocation must be submitted in writing. There are two circumstances under which we will not be able to honor your revocation request:
1. If we have already released your health information before we receive your request to revoke you authorization,
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
*If you wish to revoke your authorization please write to our Chiropractic Clinic.

B. The right to limit uses or disclosures
If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

C. Your right to receive confidential communication regarding your health information
We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home, or if you would like the information in a different form. To help us respond to your needs, please submit requests in writing.

D. Your right to inspect and copy your health information
You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

E. Your right to amend your Health Information
You have the right to request that we amend your Health Information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change your are requesting us to make.

F. Your right to receive an accounting of the disclosures we have made, if any, of your Health Information
You have the right to request that we give you an accounting of the disclosures we have made of your Health Information for the last six years before the date of your request. The accounting will include all disclosures, except:

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice (Treatment, Payment or Operations)
- those disclosures made to you
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care
- those disclosures for national security or intelligence purposes
- those disclosures made to correctional officers or law enforcement officers
- those disclosures that were made prior to April 14, 2003, the effective date of the HIPAA privacy law

G. Your right to obtain a paper copy of this Notice
We will provide a paper copy of this Notice to you, even if you have agreed to accept this notice electronically.
Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal privacy rules.
Your right to complain
You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to our Chiropractic Clinic.

If you would like further information about our privacy policies and practices please contact our office.
Effective Date: April 14, 2003, the effective date of the HIPAA privacy law.

LIVING WELL DALLAS
PH# 972-930-0260 FAX 972-559-3648

Patient Consent and Acknowledgement of Receipt of Privacy Notice
- In accordance with federal *Health Insurance Portability and Accountability Act (HIPPA)*

I understand that as part of the provision of healthcare services, Living Well Dallas creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc .) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. I also understand that the Practice and I must a) agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and b) agree to terminate any restrictions in writing on the use and disclosure of my protected health information which have been previously agreed upon.

4. My medical and care records may be disclosed to other Living Well Health & Wellness Center providers in order to manage my care including sharing diagnosis, testing results and patient care notes.

I hereby authorize Living Well Dallas and their representatives to be able to discuss my medical status and test results with the following individuals:

_____

_____ _____

Patient's Name (Printed) Date

_____

Patient's Signature (Or Guardian, if a Minor)

LIVING WELL

:health & wellness center:

CANCELLATION & RE-SCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that our policy is to make all cancellations and/or rescheduling requests at least two business days prior to the date of your appointment. As our practitioners are scheduled in hour blocks of time, we request that this policy is honored as strictly as possible. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee.

Thank you for your understanding.

Please sign here indicating that you understand and accept this policy:

_____ _____

Patient Signature **Date**