HEALTH QUESTIONNAIRE

Holistic Health and Wellness, PA

to educate, diagnose and treat individuals holistically to effect greater quality of life

Name *(Last, First, MI)*: ◻ M ◻ F		**DOB:**
Address:		
City:	**State:**	**Zip:**
Phone: (H):	**(W):**	**(C):**
Marital Status: ◻ Single ◻ Partnered ◻ Married ◻ Separated ◻ Divorced ◻ Widowed		
Spouse / Significant Other:		**# Children:**
E-Mail Address:		
Employer:		
Job Description:		

FOR MINOR CHILD		
Parent/Guardian:		
Relationship to Child:		
Address *(if different than above)*:		
Phone: (H):	**(W):**	**(C):**

REFERRAL SOURCE
Who told you about our office?

OFFICE POLICIES

PAYMENT OF BILLS

100% of services are due and payable as services are rendered. We expect you to honor the financial arrangements you make with our office. If you find that you cannot fulfill these agreements, advise our financial manager immediately so new arrangements can be made. ***A patient may not have a personal balance of more than $50.00 without having a Payment Plan Agreement***.

Any account balance over 60 days is subject to interest charges of 1 ½% per month. Failure to make payment of an over due account or to otherwise communicate within 60 days will cause the account to be placed in collections. If you are sent to collections, you will be charged a $50.00 administrative fee to cover the costs of pre-collections letters and phone calls. You are responsible for any collections costs and reasonable attorney fees allowed by law. There is a charge for all checks returned for insufficient funds. The actual charge is the maximum allowable by current law.

APPOINTMENTS

If you are unable to keep your appointment, we ask that you give us 24 hour notice for cancellations, so the time may be made available to others who may need the service. If you miss an appointment with prior notice, you will incur a charge of 60% of your appointment fee. If you cancel with less than 24 hours notice, you will incur a charge of 30% of your appointment fee. In true emergencies, neither charge will apply. What is considered an emergency is left to our discretion.

CONSENT TO TREAT MINOR

I hereby authorize the staff and health care providers at the Holistic Health and Wellness, PA to administer health care as they deem necessary to my

_______________________ _______________________________________

(relationship of child) (name of minor)

Signature of Parent/Legal Guardian _______________________________________ Date: ________________

POLICY AGREEMENT

I have read all the information stated above and I am in agreement with the policies as presented.

Signature ____ Date: ________________

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:______________________________ **Date of Birth:________________________**

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Holistic Health and Wellness, PA.

I understand that the Notice describes the uses and disclosures of my protected health information by Holistic Health and Wellness, PA and informs me of my rights with respect to my protected health information.

____ ____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

____ ____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement

Communications barriers prohibited obtaining the acknowledgement

Other (please specify):____

____ ____

Todd A. Smith, DC, DABCI *Today's Date*

Consent for Disclosure of Health Information
Additions / Exceptions List

Exclusions

I want to exclude the disclosure of any of my health information to the following providers, individuals, organizations, hospitals, and/or insurance companies:

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature

Description of personal representative's authority to act for the patient.

Additions

I want to allow the disclosure of any of my health information to the following providers, individuals, organizations, hospitals, and/or insurance companies:

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature

Description of personal representative's authority to act for the patient.

Name (*Last, First, MI)*: ☐ M ☐ F	**DOB:**
Referring Physician:	**Date of Last Physical:**

CHIEF COMPLAINT		
What is your problem?		
When did this episode begin? How did it begin?		
Have you had similar problems?	☐ No ☐ Yes, since	If so describe:
Is the problem getting worse?	☐ No ☐ Yes	
Is the problem relieved by rest?	☐ No ☐ Yes	
It interferes with	☐ Bending ☐ Carrying groceries ☐ Changing positions from seated to standing ☐ Climbing stairs ☐ Concentration ☐ Driving ☐ Extended computer use ☐ Feeding ☐ Household chores ☐ Lifting ☐ Reading ☐ Self care ☐ Sleep ☐ Sitting ☐ Standing ☐ Walking ☐ Work: ☐ Other:	
List previous diagnoses		
List previous treatment		
I am interested in	☐ Acute Care ☐ Rehabilitation ☐ Wellness	
I would be willing to participate in	☐ Exercise Program ☐ Stress Reduction ☐ Ergonomic Education (how to sit, stand, & work properly) ☐ Gain Weight ☐ Lose Weight ☐ Stop Smoking ☐ Change Diet ☐ Follow nutritional/herbal ☐ Make other lifestyle changes that are necessary recommendations	
Your Physicians	Family Physician Internist Ob/Gyn Other	

PERSONAL HEALTH HISTORY	
Childhood Illnesses	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio
Immunizations	☐ Tetanus ☐ Hepatitis ☐ Influenza ☐ Pneumonia ☐ Chickenpox ☐ MMR *(Measles, Mumps, Rubella)*
List any medical problems that other doctors have diagnosed:	

Surgeries		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?		□ Yes □ No

List your prescribed drugs and over-the-counter drugs, such as vitamins, etc.

Name of Drug	Strength	Frequency Taken

Allergies to medications

Name of Drug	Reaction You Had

Contraindications to Spinal Manipulation

Do you have any of the following conditions:

□ Acute arthropathy with inflammation, ligament laxity & dislocation around any spinal joint
□ Acute fracture / dislocation or healed fracture / dislocation with know joint instability
□ Unstable C1 or C2 vertebrae □ Myelopathy (spinal cord problems) □ Aneurysm around any vertebrae
□ Bone infection □ Malignancy of vertebra □ Vertebrobasilar insufficiency

HEALTH HABITS AND PERSONAL SAFETY		
Exercise	□ Sedentary (no exercise) □ Mild exercise (climb stairs, golf, walking) □ Occasional vigorous exercise (work/recreation, 30 minutes, less than 4x/week) □ Regular vigorous exercise (work/recreation, 30 minutes, 4x/week or more)	
Diet	Are you dieting?	□ Yes □ No
	If yes, are you on a physician prescribed diet?	□ Yes □ No
	# of meals you eat each day	
	Rank salt intake	□ High □ Medium □ Low
	Rank fat intake	□ High □ Medium □ Low
Caffeine	□ None □ Coffee-reg □ Coffee-decaf □ Tea □ Cola	
	# of cups per day?	
Water	□ None □ Tap □ Filtered □ Bottled	
	# of cups per day?	
Alcohol	Do you drink alcohol?	□ Yes □ No
	If yes what kind?	
	How many drinks per week?	
	Are you concerned about the amount you drink?	□ Yes □ No
	Have you considered stopping?	□ Yes □ No
	Have you ever experienced blackouts?	□ Yes □ No
	Are you prone to binge drinking?	□ Yes □ No
	Do you drive after drinking?	□ Yes □ No
Tobacco	Do you use tobacco?	□ Yes □ No
	□ Cigarettes, packs/day =( ) □ Chew, # per day=( ) □ Pipe, # bowels/day=( ) □ Cigars, # per day=( )	
	□ # of years used = ( ) □ or year quit = ( )	
Drugs	Do you currently use recreational drugs?	□ Yes □ No
	Have you ever used needle to inject the drugs?	□ Yes □ No

Sex	Are you sexually active?	□ Yes □ No
	If yes, are you trying for a pregnancy?	□ Yes □ No
	If not, list contraceptive or barrier method used:	
	Any discomfort with intercourse?	□ Yes □ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	□ Yes □ No
Personal Safety	Do you live alone?	□ Yes □ No
	Do you have frequent falls?	□ Yes □ No
	Do you have vision or hearing loss?	□ Yes □ No
	Do you have an Advance Directive or Living Will?	□ Yes □ No
	Would you like information of the preparation of these?	□ Yes □ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		**Grandmother** *Maternal*		
	□ M □ F		**Grandfather** *Maternal*		
	□ M □ F		**Grandmother** *Paternal*		
	□ M □ F		**Grandfather** *Paternal*		

MENTAL HEALTH	
Is stress a major problem for you?	□ Yes □ No
Do you feel depressed?	□ Yes □ No
Do you panic when stressed?	□ Yes □ No
Do you have problems with eating or your appetite?	□ Yes □ No
Do you cry frequently?	□ Yes □ No
Have you ever attempted suicide?	□ Yes □ No
Do you have trouble sleeping?	□ Yes □ No

WOMEN ONLY	
Age at onset of menstruation:	
Date of last menstruation:	
Period every _________ days	
Heavy periods, irregularity, spotting, pain, or discharge?	□ Yes □ No
Number of pregnancies _____, Number of live births _____	
Are you pregnant or breast feeding?	□ Yes □ No
Have you had a D&C, hysterectomy, or Cesarean?	□ Yes □ No
Any urinary tract, bladder, or kidney infections within the last year?	□ Yes □ No
Any blood in your urine?	□ Yes □ No
Any problems with control of urination?	□ Yes □ No
Any hot flashes or sweating at night?	□ Yes □ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	□ Yes □ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□ Yes □ No
Date of last PAP and rectal exam:	

MEN ONLY	
Do you usually get up to urinate during the night?	□ Yes □ No
If yes, # of times ______	
Do you feel pain or burning with urination?	□ Yes □ No
Any blood in your urine?	□ Yes □ No
Do you feel any burning discharge from the penis?	□ Yes □ No
Has the force of your urination decreased?	□ Yes □ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	□ Yes □ No
Do you have any problems emptying your bladder completely?	□ Yes □ No
Any difficulty with erection or ejaculation?	□ Yes □ No
Any testicle pain or swelling?	□ Yes □ No
Date of last prostate and rectal exam:	

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
□ Skin	□ Chest/Heart	□ Recent changes in:
□ Head/Neck	□ Back	□ Weight
□ Ears	□ Intestinal	□ Energy level
□ Nose	□ Bladder	□ Ability to sleep
□ Throat	□ Bowel	□ Other pain/discomfort:
□ Lungs	□ Circulation	

VITALS		
B/P:	Pulse: ______ Temp: ______	Height: ______ Weight: ______
Supine B/P:	Standing B/P:	30’ Recover B/P:

INFORMED CONSENT

PATIENT NAME:

DATE:

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions of the doctor before you sign.

TRADITIONAL CHIROPRACTIC TREATMENT (muscle and joint problems)

The nature of the chiropractic adjustment
The primary treatment used is joint manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon you body in such a way as to move you joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As part of the analysis, examination, and treatment, you are consenting to the following procedures if needed:

- manipulative therapy
- range of motion testing
- neurological testing
- orthopedic testing
- palpation
- vital signs
- muscle strength testing
- postural analysis
- hot/cold therapy
- ultrasound treatment
- electrical muscle stimulation
- traction

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stoke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur around 1 in 4 million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include:

- self-administered over-the-counter analgesics and rest
- medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- hospitalization
- surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

INFORMED CONSENT (cont)

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Todd A. Smith and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Dated: _______________ **Dated: _______________**

___________________________________ Todd A. Smith, DC, DABCI
Patient's Name

___________________________________ ___________________________________
Signature **Signature**

____
Signature of Parent or Guardian (if minor)
or patient's representative