Core Wellness Centers, Inc.

8481 Fishers Center Drive
Fishers, In 46038
317-570-1944

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible. Please print legibly. Thank you.

PERSONAL INFORMATION

Last name: ________________________ First name: __________________________ Middle: _____

Date of Birth: _____/_____/_________ Age: _____ Sex: M F SSN: _____-____-__________

Address: ____ City: _______________ Zip: ___________

(H) Phone: (____)______-______ (W) Phone: (____)______-_____ (C) Phone: (____)_____-_____

Marital Status: ___M ___S ___W ___D Spouse's Name: ________________________________

Business/Employer: ____________________ Type of Work Performed: _________________________

In Case of Emergency Notify: __________________________________ Phone: (____)______-______

Name of Family Physician: _____________________________________ Phone: (____)______-______

Who referred you to our office? __________________________________

E-mail address: ____________________________________

CURRENT HEALTH CONDITION

Main or Primary Complaint:

____

____

How Severe Is This Problem:_ Mild _ Moderate _ Severe

Previous Occurrences: _ Yes _ No

When Did This Condition Begin:__________________

Other Doctors Seen For this Complaint: ___________________________________

Previous Doctor's Opinion/Diagnosis: _________________________________

Is Condition:_ Job Related _ Auto Related _ Injury Other: _______________________________

Other or Secondary Complaints: ______________________________________

Other Health Problems: _ Yes _ No If "Yes", please describe: __________________________

Drugs or Medicines Now Taking:

_ Pain Killers / Muscle Relaxers _ Blood Pressure Medicine _Stomach _ Tranquilizers _ Antibiotics Other: __________________

PAST HEALTH HISTORY

Major Surgeries/Operations: _ Head _ Neck/Throat _ Chest/Heart/Lung _ Back _ Abdominal Other:_____________

Previous Fractures or Broken Bones: _ Yes _ No What: ________________________________

Previous Falls or Accidents: _ Yes _ No When:________________________________

Previous Hospitalization: _ Yes _ No Why:________________________________

Previous Chiropractic Care: _ Yes _ No Doctor:________________________________

Has Anyone Else In Your Family Had A Similar Problem? _ Yes _ No

Has Anyone With Whom You've Worked Had A Similar Problem? _ Yes _ No

Do You Participate In Any Sports or Exercise Programs? _ Yes _ No

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as carefully as possible.

Check any of the following that applies to you:

_ Polio
_ Diabetes
_ Cancer
_ Other:___________________
_ Heart Disease
_ Chronic Fatigue

_ Arthritis
_ Epilepsy
_ AIDS or ARC
_ Tobacco
_ Frequent Illnesses
_ Allergies

INTAKE or *USE*
_ Alcohol
_ Recreational Drugs
_ Pain Relievers
_ Prescribed Drugs

Check any problem that you have had in the past 6 months:

Muscles-Skeleton
_ Low Back Pain
_ Pain Between Shoulders
_ Neck Pain
_ Arm Pain
_ Joint Pain/Stiffness
_ Problems Walking
_ Difficulty Chewing - TMJ
_ General *Stiffness*

Circulation-Breathing
_ Chest Pain
_ Shortness of Breath
_ Blood Pressure Problems
_ Irregular Heart Rate
_ Heart Problems
_ Lung Problems
_ Stroke

Eye-Ear-Nose-Throat
_ Visual Disturbances
_ Dental Problems
_ Sore Throat
_ Ear Aches
_ Difficulty Hearing
_ Stuffy Nose
_ Sinus Drainage/Pain
_ Pain - Forehead or Face

Nerve System
_ Headaches _ Poor Appetite
_ Nervousness
_ Numbness/Tingling
_ Muscular Weakness
_ Dizziness
_ Forgetfulness _ Hemorrhoids
_ Depression _ Weight Loss/Gain
_ Fainting
_ Convulsions/Seizures
_ Cold Hands Feet
_ Stress
_ Shaking/Tremors

Digestion-Elimination
_ Pain with Urination
_ Excessive Thirst
_ Frequent Nausea
_ Diarrhea
_ Constipation
_ Pain in Genitals

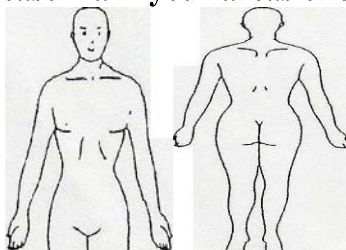
Female Only
_ Gas/Bloating
_ Heartburn
_ Change in Stools

Urinary-Genitals
_ Infrequent Urination
_ Frequent Urination
_ Weak Urine Stream
_ Loss Of Bladder Control

_ Menstrual Pain/Irregularity
_ Low Back Pain w/ Periods
_ Breast Pain/Lumps

Are You Pregnant? _ Yes _ No _ Not Sure

Please mark your areas of complaint:



(X) Pain (0) Spasm (*) Numb

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor nor relied upon by me. I further understand that the doctor's professional expertise lies in detecting and correcting structural and mechanical aberrations of the spine. I agree that he will not be held responsible for the diagnosis or treatment of any medical condition.

Patient's Signature: ___________________________ Date: _____________

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SF-12 Health Survey

Patient Name: ___________________________________ Date: _____________

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. *In general, would you say your health is:*

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

2. *The following items are about activities you might do during* a *typical day. Does your health now limit you in these activities? If so, how much?*

	Limited a lot	Limited a little	No, not limited
a. *Moderate activates, such as moving* a *table, pushing* a *vacuum cleaner, bowling, or playing golf?*	1.	2.	3.
b. *Climbing several flights of stairs?*	1.	2.	3.

3. *During the past* 4 *weeks, have you had any of the following problems with your work or other regular daily activities* as a *result* of *your physical health?*

	Yes	No
a. *Accomplished less than you would like.*	1.	2.
b. *Were limited in the kind of work or other activities.*	1.	2.

4. *During the past* 4 *weeks, have you had any of the following problems with your work or other regular daily activities* as a *result* of *any emotional problems (such as feeling depressed or anxious)?*

	Yes	No
a. *Accomplished less than you would like*	1.	2.
b. *Didn't do work or other activities* as *carefully as usual*	1.	2.

5. *During the past* 4 *weeks, how much did pain interfere 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. *These questions are about how you feel and how things have been with you during the past* 4 *weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past* 4 *weeks....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. *Have you felt calm and peaceful?*	1.	2.	3.	4.	5.	6.
b. Did you have a *lot of energy?*	1.	2.	3.	4.	5.	6.
c. *Have you felt downhearted and blue?*	1.	2.	3.	4.	5.	6.

7. *During the past* 4 *weeks, how much of the time has your physical health or emotional problems 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

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DOCTOR-PATIENT RELATIONSHIP
AND
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Patient's Signature: ____________________________ Date: _____________

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Patient Health Information Consent Form
(Notice of HIPAA Privacy Practices)

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 need 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 effect 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, the staff has 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 assure 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.

Patient's Signature: ___________________________ Date: _____________

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SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I permit a copy of this authorization to be used in place of the original
- I understand that there will be a $25 charge to my account for not canceling appointments within 24 hours.

Name (please print) ______________________________

Signature: _______________________________________ **Date:** ________________

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Authorization For Release of Records to be Transferred

To: ______________________________

From: ______________________________

I hereby request and authorize you, your employees, and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including X-rays and photo static copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward the reports and information requested to:

Shannon J. Wise, D.C
8481 Fishers Center Dr.
Fishers, IN 46038

I understand that all records, including diagnostic imaging studies, are the property of Wise Chiropractic Center, P.C. and therefore I will be charged a duplication fee upon request of file release.

Name of Patient (Please Print): ______________________________

Date of Records: ______________________________

Signature: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________________

Signature of Parent or Guardian: ______________________________

Today's Date: ______________________________