ABOUT YOU

First Name _____ Middle Name _____ Last Name_____

Street Address _____
City _____ State _____ Zip _____
Mobile Phone____-____-_____ Work Phone____-____-_____ Home Phone ____-____-_____
Email Address_____

Date of Birth ____ / ____ / _____ Gender ⌐ Male ⌐ Female

Marital Status ⌐ Single ⌐ Married ⌐ Divorced

PARENTS / GUARDIAN INFORMATION (FOR MINORS)

Who is financially responsible? ⌐ Mother ⌐ Father

Responsible Party Full Name: _____

Mobile Phone ____-____-_____ Work Phone ____-____-_____ Home Phone ____-____-_____
Street Address _____
City _____ State _____ Zip _____
Date of Birth: _____ Social Security Number: _____

EMERGENCY CONTACT INFORMATION

Full Name_____
Phone _____-_____-_____ Relation to Patient:_____

INSURANCE / BILLING INFORMATION

Insurance Company Name: _____

Insurance Company Provider Phone Number: _____

Member ID/Policy Number _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth_____

Patient Relationship to Policy Holder: _____

REFERRAL INFORMATION

Referring Physician _____ Contact Info _____

Referring Patient _____

How Did You Hear About Us?
⌐ Word of Mouth ⌐ Advertisement ⌐ Social Media ⌐ Direct Marketing ⌐ Internet

ACCIDENT INFORMATION

Is this injury related to: ☐ Auto Accident ☐ Work Accident ☐ Other Accident ☐ No Accident

Date of Accident:_____ What state did the accident occur in: _____
Have you filed your claim with YOUR auto insurance? ☐ Yes ☐ No

Have you filed your claim with your employer? ☐ Yes ☐ No
If yes, what is the name of your Superior?_____

Are you working with an Attorney? ☐ Yes ☐ No
Attorney's Name: _____ Phone Number: _____

READ AND CHECK BOXES BELOW:

☐ I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

☐ The Notice of Privacy Practices (HIPAA) describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. I acknowledge and understand the HIPAA Privacy Practice Notice. Full copies are available upon request.

I certify that this information provided to the doctor is true and accurate to the best of my knowledge.

*Patient's Signature:*_____ *Date:*____/____/____

Parent / Guardian Signature: _____ *Date:*____/____/____

Print Name: _____

REASON FOR VISIT

DATE: ____ / ____ / _____

How long have you had this complaint?

- ⌐ Less than 5 days (Acute)
- ⌐ Between 5-30 days (Sub Acute)
- ⌐ More than 30 days (Chronic)

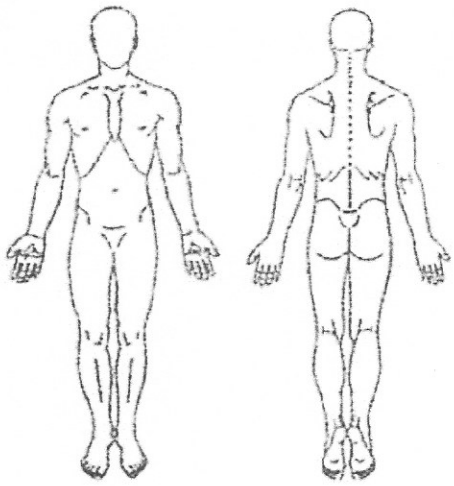
What caused this condition? _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W- weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ⌐ Constant ⌐ Frequent ⌐ Random ⌐ Intermittent

How has this complaint changed since the onset? ⌐ Worsened ⌐ Remained the same ⌐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment have you received for this condition up to now? _____

_____

What activity/position aggravates this condition? _____

What activity/position improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? Do you have the results/reports/xray/MRI? _____

Have you ever had any previous episodes of this condition? _____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints ☐ No ☐ Yes Explain: _____

Nerves, Headaches, Dizziness, or Emotional ☐ No ☐ Yes Explain: _____

Head, Eyes, Ears, Nose or Throat ☐ No ☐ Yes Explain: _____

Heart, Blood Pressure, or Circulation ☐ No ☐ Yes Explain: _____

Shortness of Breath, Coughing, Asthma or Lung Condition ☐ No ☐ Yes Explain: _____

Stomach, Bowels or Digestive Conditions ☐ No ☐ Yes Explain: _____

Genital, Bladder, or Urinary Conditions ☐ No ☐ Yes Explain: _____

Diabetes, Thyroid or Glandular Conditions ☐ No ☐ Yes Explain: _____

Skin or Bleeding Conditions ☐ No ☐ Yes Explain: _____

Allergies or Sensitivities ☐ No ☐ Yes Explain: _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes Explain: _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes Explain: _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes Explain: _____

Are you presently taking any medication? ☐ No ☐ Yes Explain: _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes Explain: _____

WORK AND SOCIAL HABITS

Current work habits: select all that apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits: select all that apply

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits: select all that apply

- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits: select all that apply

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

Wheaton Healthcare, LLC

CONSENT TO CARE

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that in unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The classic treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I may use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause and audible "pop" or "click," much as you experienced when you "crack" your knuckles. You may feel a sense of movement.

ANALYSIS / EXAMINATION / TREATMENT

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
Range of motion testing, postural analysis, spinal manipulation therapy, muscle strength testing, vital signs, myofascial release, basic neurological testing, palpation, tool assisted myofascial release, orthopedic testing, therapeutic exercise, hot/cold therapy, functional movement screens, ultrasound, EMS.

THE MATERIAL RISKS INHERENT TO CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation 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 or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen 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 and X-ray. Stroke has been subject to tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one and five million cervical adjustments. The other complications are also generally rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENTS

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 OF REMAINING UNTREATED

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.

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. 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 that treatment.

Print
Name_____Date_____

Signature/Guardian's signature _____

Wheaton Healthcare, LLC

Insurance

- Patient is responsible for understanding their insurance benefits.
- Wheaton Healthcare, LLC is not responsible for providing benefit information and that any information given to Patient is not a guarantee of benefits.
- Wheaton Healthcare, LLC will submit all claims to Primary and Secondary Carriers (if applicable).
- Patient authorizes Wheaton Healthcare, LLC to submit insurance claims on their behalf, and to accept payment of medical benefits for services rendered.
- Patient authorizes Wheaton Healthcare, LLC to initiate a complaint to their Insurance Company, and or Insurance Commissioner on their behalf.
- Patient authorizes the release of medical information to their Insurance Company, Adjuster, or Attorney involved in the processing of their claims.
- In the event that Patient's Insurance Company remits payment to Wheaton Healthcare, LLC with a check made out in Patient's name, Patient authorizes Wheaton Healthcare, LLC to deposit that payment and credit Patient's account accordingly.

Financial Agreement and Patient Balances

- Patient is ultimately responsible for their account balance regardless of insurance coverage.
- Wheaton Healthcare, LLC will ask for a copy of a major credit card to keep on file in a secure server. Patient authorizes Wheaton Healthcare, LLC to charge their credit card on file with any unpaid balances that are greater than 30 days old that exist after the Insurance Company sends payment for that claim.
- Patient will provide new contact and credit card information to Wheaton Healthcare, LLC front desk whenever the information changes.
- Wheaton Healthcare, LLC will send monthly statements to Patients with current balances.
- Patient is responsible for payment of medical services rendered.
- Patient is responsible for any co-payment, co-insurance, deductible and/or non-covered services.
- There will be a $35 service charge for returned or bounced checks.
- If your account is turned over to an outside collection agency, your balance will be increased by 33% to cover the cost of the collection agency's fee.

Missed or Late Appointments

- Appointment times are reserved for you and we make every effort to keep to our scheduled appointment times. If you are more than 5 minutes late for an appointment, we will ask for you to reschedule in order to get the full attention from our treatment staff.
- Patient understands that there will be a $50 charge for missed or cancelled appointments unless 24 hour notice has been given to Wheaton Healthcare, LLC. The card you have on file will be processed at the time of the missed appointment.

I understand and accept the terms of the Financial and Office Policy listed above.

Print Patient Name_____Print Parent or Guardian Name:_____

Signature of Patient or Parent or Guardian_____Date: _____