

Is this visit due to an auto or workman's comp accident? NO / YES

(If yes, please inform the front desk of this if you haven't already.)

Name:			C)ate:	/
Address:					
City:					
Home Phone:	Work F	Phone:	Cell Pho	one:	
Would you like text reminders?	No/Yes \	Who is your cell ph	one carrier?		
Email Address:			Occupation: _		
Date of Birth:	Gender:	Male / Female	Social Security #:		
Race: American Indian / Asian /	Black or Africa	n American / Nati	ve Islander / White /	Decline	
Ethnicity: Hispanic-Latino / Non	-Hispanic-Latin	o / Decline Pre	ferred Language:		
Are you Pregnant? Yes / No	Number of Ch	ildren: Ma	rital Status:		
Primary Care Physician Name:_		Clinic Name	e/Location:		
Who may we thank for referring	you to our offic	ce?			
Have you had x-rays, MRI, or CT	scans complete	ed? (if yes) When/\	Vhere/Area of body:_		
Do you consume caffeine?	No/Yes	< 3 Drinks/day	3-6 Drinks/day	У	>6 Drinks/day
Do you consume alcohol?	No/Yes	Casual Drinker	Moderate Drii	nker	Heavy Drinker
Do you smoke?	No/Yes	Current Smoke (Since :)	ormer Smo	oker (Quit when)
Do you use drugs?	No/Yes	Recreational (_)	Addiction	on Former Addict
Do you exercise? No/Ye	es Daily	Weekly	Walks Runs	Swims	
List ALL Allergies (Medications/ F	Food/Environme	ental <u>) :</u>			
List ALL Surgeries (DATES INCLU	DED):				
List ALL Medical History condition	ons:				
List ALL Medications/Vitamins	you are taking	(DATE STARTED a	s well as dosage) If y	you have	a medication list, please
provide that instead	-				
		-			



Family Health History: Please write down any/all medical histor	les below that apply to the following family members.					
Father:	Mother:					
Brothers:	Sisters:					
Son:	_ Daughter:					
Circle any activities of daily living that are currently affected due to your pain/discomfort						
Dressing, Grooming, Walking, Sitting, Standing, Sitting	g to Standing, In/out of bed, Transfers, Lifting,					
Climbing Stairs, Housework, Driving, Sleep, Childcare,						
Exercises Affected? (list exercise activities)	Other:					

List/Circle all Medical History conditions please read through the full list as it is important to your care and circle NONE if nothing applies.

Unexplained weight loss, night sweats, fatigue, appetite, fever, itch/rash, recent trauma,	NONE
lumps/bumps/masses, unexplained falls	
Visual changes, headaches, eye pain, double vision, blind spots,	NONE
Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears,	NONE
gingival bleeding, toothache, sore throat, pain with swallowing	
Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of	NONE
consciousness, calf pain when walking, high blood pressure, high cholesterol	
Coughing, coughing blood, wheeze, shortness of breath	NONE
Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting,	NONE
diarrhea/constipation, vomiting blood, abnormal stool	
Incontinence, blood in urine, frequent urination, trouble urinating, menopause	NONE
Pain, stiffness, joint swelling, decreased range of motion, arthritis	NONE
Itching, rashes, wounds, tumors, eczema, excessive dryness,	NONE
Breast: pain, soreness, lumps, or discharge	
Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control	NONE
Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality	NONE
	NONE
Hypothyroid : prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin	
Diabetes: Frequent urination, increased appetite, increased thirst, dizziness, sweating,	
headache	
Anemia, bruising easily, family history of blood issues, history of blood transfusion	NONE
	lumps/bumps/masses, unexplained falls Visual changes, headaches, eye pain, double vision, blind spots, Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears, gingival bleeding, toothache, sore throat, pain with swallowing Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of consciousness, calf pain when walking, high blood pressure, high cholesterol Coughing, coughing blood, wheeze, shortness of breath Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, vomiting blood, abnormal stool Incontinence, blood in urine, frequent urination, trouble urinating, menopause Pain, stiffness, joint swelling, decreased range of motion, arthritis Itching, rashes, wounds, tumors, eczema, excessive dryness, Breast: pain, soreness, lumps, or discharge Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality Hyperthyroid: prefer cold weather, mood swings, sweaty, diarrhea, weight loss. Hypothyroid: prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin Diabetes: Frequent urination, increased appetite, increased thirst, dizziness, sweating, headache



For the following, please only fill out/circle what applies

NECK PAIN			te Pain	. 10		How did pain start?					
Date Started:	(∿	, ,	-5-6-7-8-9 lerate) h side?				•	similar pair	·	•	
			nter/Right	<u>t</u>		<i>DO</i> ,	ou nave i	adiating pa	iii. (Wileic	•,	
Is the pain	Constant 100-75% d	1 ,			rmittent Occasional 25% of time 25-0% of time						
Is the pain →	Sharp	Shooting	Stabbing	g Achy	Dull	Th	robbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresse		ernoon	Even	ing	During ¹	the night	Stays	s consistent	
What time of day does your pain feel WORSE →	Morning	As the day progresse		ernoon	Even	ing	During ¹	the night	Stays	s consistent	
What makes the pain feel better? →	Resting	Stretching	; lce	N	1edicati	on	Chiropr Care	actic Ot	:her:		
What makes the pain feel worse? →	Working	Standing	Twist	ting N	1oveme	nt	Walking		:her:		

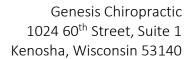
UPPER/ MIDBACK PAIN	/N4:1d		5-6-7-8-9-10				did pain		1.6.20		
111111111111111111111111111111111111111	(Mild) (Moder	ate) (Sever	e)		Have	you had	similar pain	before? (V	vnen?)	
Date	Side			Do yo	ou have r	adiating pai	n? (Where	?)			
Started:		Left/Ce	nter/Right								
Is the pain	Constant		Frequently		Inte	ermitt	ent	Occas	sional		
→	100-75%	of time	75-50% of t	ime	50-	-25% c	of time	25-0%	% of time		
Is the pain →	Sharp	Shooting	Stabbing	Achy	Dull	Thr	obbing	Tingling	Numb	Burning	Tight
What time of day		As the da	У								
does your pain feel BEST →	Morning	progresse	es Afteri	noon	Eveni	ing	During	the night	Stays	consistent	
What time of day	Morning	As the da	y Afteri	noon	Eveni	ing	During	the night	Stays	consistent	
does your pain feel WORSE →		progresse	es								
What makes the pain							Chiropr	actic Otl	ner:		
feel better? →	Resting	Stretchin	g Ice	M	edicatio	on	Care				
What makes the pain								Otl	ner:		
feel worse? →	Working	Standing	Twisting	g M	oveme	nt	Walking	3			



For the following, please only fill out/circle what applies

LOW BACK PAIN	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)			How did pain start? Have you had similar pain before? (When?)							
Date Started:			<u>ch side</u> nter/Right			Do y	ou have r	adiating pai	n? (Where	?)	
Is the pain	Constant		Frequently	/	Int	ermit	tent	Occa	sional		
→	100-75%	of time	75-50% of	time	50-	25%	of time	25-09	% of time		
Is the pain \rightarrow	Sharp	Shooting	Stabbing	Achy	Dull	Th	robbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the da	•	rnoon	Even	ing	During ¹	the night	Stays	consistent	
What time of day does your pain feel WORSE →	Morning	As the da progresse	•	rnoon	Even	ing	During ¹	the night	Stays	consistent	
What makes the pain feel better? →	Resting	Stretching	g lce	М	edicati	on	Chiropr Care	actic Ot	her:		
What makes the pain feel worse? →	Working	Standing	Twistiı	ng M	oveme	nt	Walking		her:		

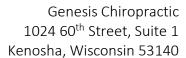
OTHER: Date Started:	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Side Left/Center/Right			How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)							
Is the pain	Constant 100-75%	of time	Frequently 75-50% of			ermitt -25% (tent of time		sional % of time		
Is the pain →	Sharp	Shooting	Stabbing	Achy	Dull	Thi	robbing	Tingling	Numb	Burning	Tight
What time of day		As the da	У								
does your pain feel BEST →	Morning	progresse	es Afte	rnoon	Even	ing	During	the night	Stays	s consistent	
What time of day does your pain feel WORSE →	Morning	As the da progresse	•	rnoon	Even	ing	During t	the night	Stays	consistent	
What makes the pain feel better? →	Resting	Stretching	g lce	M	edicati	on	Chiropr Care	actic Ot	her:		
What makes the pain feel worse? →	Working	Standing	Twistir	ng M	oveme	nt	Walking		her:		





HIPPA – ACKNOWLEDGEMENT OF RECEIPT Notice of Privacy Practices

We at Genesis Chiropractic Wellness and Rehabilitation Center privacy of and provide individuals with the attached Notice of respect to protected health information. If you have any obje with our HIPPA Compliance Officer in person or by our main put the Notice, please ask. I hereby acknowledge that I have review document.	our legal duties and privacy practices with ctions to the Notice, please ask to speak phone number. If you would like a copy of
Printed name of patient or patient's representative/parent	Date
Signature of patient or patient's representative/parent	
Consent to X-ray and Verification I hereby state that to the best of my knowledge I am not pregnanty trying to become pregnant. I also state that pregnancy is neither at this time. I release Genesis Chiropractic Clinic Inc. from any them to complete any radiology examination deemed necess	nant and am not actively her suspected nor confirmed v liability and authorize
Printed name of patient or patient's representative/parent	Date
Signature of patient or patient's representative/parent	
Communication Method Discletion Genesis Chiropractic Clinic Inc communicates with its patient pinformation the patient or the patient's representative/parent phone, text messaging, email, fax and U.S. mail. By providing registration process, you: 1. Consent and agree to receive tele communications. These calls may be in regard to services receive financial obligations related to those services. I understate future medical service accounts for which I am the Guarantor such calls, messages, or other communications by your wireled responsibility to inform Genesis Chiropractic Clinic Inc if I choose withdraw this consent at any time by contacting Genesis Chiropractic Genesis C	population in a variety of ways. We use at provides, including landline phone, cell your cell phone number during the ephone calls, text messages and other eived at Genesis Chiropractic Clinic Inc and and this consent applies to all current and and the consent applies to all current and are 2. Understand you may be charged for eass carrier. 3. I understand it is my use to withdraw this permission. I can
understand, and agree to the above:	
Printed name of patient or patient's representative/parent Signature of patient or patient's representative/parent	Date
oignature or patient or patient's representative/parent	





INFORMED CONSENT

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal; to identify and correct subluxations. 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.

- **1. Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral/extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities
- 2. Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.
- **3. Vertebral Subluxation:** 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.
- **4. Extremity Subluxation:** A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, do an analysis, and then develop a treatment for the extremity.

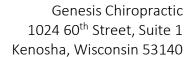
We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral. We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your health!

Chiropractic care, while rare and unlikely, has risk factors. Most are self-limiting but rare serious risk factors include fracture, exacerbation of a disc herniation, and stroke.

Privacy and Sharing of Information

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 require you to read and sign this consent form stating that you understand and agree with how your records will be used.

- 1. The patient understands and agrees to allow this chiropractic office to use their 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 affect 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, all 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, our office has the right to refuse to give care.

X-Ray Release

This is to certify that **practitioners at Genesis Chiropractic have my permission to perform an X-ray evaluation**. I have been advised that x-ray can be hazardous to an unborn child and, if applicable, will inform Genesis Chiropractic if I am or might be pregnant. If I am pregnant, I consent to receive an x-ray once it is safe to do so.

I hereby authorize any medical facility to release my previous films/images and reports to Genesis Chiropractic for comparative purposes. In addition, I authorize Meier Family Chiropractic to release my films/images to any other facility for comparative purposes or to a radiologist for review of my films/images.

Consent to Care for Minor

If applicable, I authorize providers at Genesis Chiropractic to administer care necessary to my son/daughter.

Insurance & Financial Responsibility

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Genesis Chiropractic 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 Genesis Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits.

I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered to me will be immediately due and payable.

I understand that cancellations must be communicated prior to my appointment. A no call/no show will result in a fee except in the event of an emergency. I understand that a no call/no show fee will be collected at the time of my missed appointment.

I have read and fully understand the above statements. All questions regarding the doctor's objectives

pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.					
Printed name of patient or patient's representative/parent	Date				
Signature of patient or patient's representative/parent					



FEES AND PAYMENTS

Payment in full is due at the time services are rendered. We urge patients to be familiar with their chiropractic insurance benefits prior to appointment. Our office staff calls and verifies your insurance benefits if you need to be informed. Co pays and deductibles are due at time of service or your appointment may be rescheduled. If payment arrangements need to be made, please speak with our office staff to make payment arrangements. Billing your insurance company does not ensure payment, in cases of partial payment OR denial (unless stated otherwise by your insurance carrier) you are responsible for the remaining balance. You are responsible to inform our office of any changes to your insurance policy prior to your visit at our facility, not doing so can result in timely filing, in which the unpaid claim will become your responsibility

WELLNESS/MAINTENANCE CARE

Most insurance companies do not pay for maintenance care. Maintenance care is deemed **medically unnecessary** through insurance companies. Some verbiage your insurance company might use to describe medically unnecessary treatment is as follows:

- Treatment for a chronic condition if there is no reasonable expectation of improvement.
- Treatment to prevent a relapse or exacerbation of a condition (maintenance)
- Treatment dates over a 2-4 weeks interval
- Long term treatment for the same or similar condition

This notice is to inform you of possible non-covered services that you may be responsible for payment.

Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

Printed name of patient or patient's representative/parent	Date	
Signature of patient or patient's representative/parent		



AUTHORIZED CONSENT FORM

l,	authorize the following people to accompany and discuss
any and all chiropractic treatment	at Genesis Chiropractic Wellness and Rehabilitation Center, pertaining to medical treatment, diagnosis, prognosis, and
1	Relationship to Patient
	Phone #
2	Relationship to Patient
	Phone #
3	Relationship to Patient
	Phone #
Printed name of patient or patient's r	representative/parent Date
Signature of patient or patient's repre	esentative/parent