

# CONFIDENTIAL PATIENT INFORMATION

**ABSOLUTE**  
Wellness



Name \_\_\_\_\_ SSN \_\_\_\_\_ Date \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_ Sex ☐ M ☐ F Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_ Marital Status S M W D  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Have you had chiropractic care previously? ☐ No ☐ Yes When \_\_\_\_\_ Doctor's Name \_\_\_\_\_  
 Would you like to receive reminders? ☐ Text ☐ Email Cellular Carrier \_\_\_\_\_  
 Please list your most recent traumas with date of occurrence. (Auto Accidents, Falls, Sports Injuries, Etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	PRIMARY CONCERN	SECONDARY CONCERN
Please describe concerns and symptoms that are causing you to seek treatment.	_____	_____
When did symptoms start?	_____	_____
Have you had these symptoms previously?	<input type="checkbox"/> Yes, when? _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes, when? _____ <input type="checkbox"/> No
The pain is...	<input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes <input type="checkbox"/> Dull <input type="checkbox"/> Burning <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Causing Restrictions <input type="checkbox"/> Causing Weakness <input type="checkbox"/> Traveling, where? _____	<input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes <input type="checkbox"/> Dull <input type="checkbox"/> Burning <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Causing Restrictions <input type="checkbox"/> Causing Weakness <input type="checkbox"/> Traveling, where? _____
What makes the pain better?	<input type="checkbox"/> Chiropractic Care <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Resting <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying Down <input type="checkbox"/> Other _____	<input type="checkbox"/> Chiropractic Care <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Resting <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying Down <input type="checkbox"/> Other _____
What makes the pain worse?	<input type="checkbox"/> Bowel Movements <input type="checkbox"/> Driving <input type="checkbox"/> Breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sneezing <input type="checkbox"/> Working <input type="checkbox"/> Other _____	<input type="checkbox"/> Bowel Movements <input type="checkbox"/> Driving <input type="checkbox"/> Breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sneezing <input type="checkbox"/> Working <input type="checkbox"/> Other _____
Have you missed any work/school due to this complaint?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this issue the result of an automobile accident or work-related injury? Explain.	<input type="checkbox"/> Automobile Accident <input type="checkbox"/> Work-Related _____ _____	<input type="checkbox"/> Automobile Accident <input type="checkbox"/> Work-Related _____ _____
Have you received any other treatment for this issue? What type?	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____ Physician's Name _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____ Physician's Name _____
Please mark your areas of pain on the figure. Use the corresponding character to indicate the type of pain in each area.  ++ Sharp/Stabbing    ## Burning XX Tingling/Numb    00 Dull		
Please circle the activities that are affected by this issue.	Bathing    Sleeping    Brushing Teeth    Caring for Family Cooking    Dressing    Climbing Stairs    Computer Use Driving    Eating    Concentration    Daily Pet Care Sports    Bending    Sneezing    Exercising Shaving    Reaching    Showering    Sexual Activities Reading    Running    Swallowing    Yard Work	Carrying Items    Washing Body/Hair Lifting Items    Changing Positions Work Activities    Getting Out of Bed Lying Down    Household Chores Static Sitting

**Medication** Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your doctor.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**Nutrients** Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**Females Only** Are you currently having menstrual cycles? Y N

If yes, when was the first day of your last cycle? \_\_\_\_\_ Is there any chance you are pregnant? Y N

**Family History** Insert ages and check any box that applies.

	Age (if living)	Heart Dx	High Cholest	High BI Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other												

**Diet** Indicate if the substance is used, type, how much, how often.

Substance	Used?	Type	How Much/How Often
Water	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Glasses Per Day
Caffeinated Beverages	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Per Day
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Per Week
Fast Food	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Per Week
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Per Day
Fruits/Vegetables	<input type="checkbox"/> Yes <input type="checkbox"/> No		____ Servings Per Day

**Body Composition/Exercise** Please fill in the chart.

Current Weight	_____	
Ideal Weight	_____	
Interested in Weight Management?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How Often
Cardio Exercises	<input type="checkbox"/> Yes, type? _____ <input type="checkbox"/> No	____ Per Week
Resistance/Weight Training	<input type="checkbox"/> Yes, type? _____ <input type="checkbox"/> No	____ Per Week
Pain After Exercise?	<input type="checkbox"/> Yes, where? _____ <input type="checkbox"/> No	
Play Sports?	<input type="checkbox"/> Yes, type? _____ <input type="checkbox"/> No	

### Commitment/Goals

From 1-10, what is your daily stress level? \_\_\_\_\_

From 1-10, how committed are you to making lifestyle improvements? \_\_\_\_\_

What are your health goals for the next six months? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Primary Care Physician

Physician's Name \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ Check here if you do NOT authorize this office to communicate with my primary physician about the care I receive.

Signature \_\_\_\_\_

**Subjective Health Assessment** Please rate the following symptoms that you have experienced during the past 30 days.

0= Never    1= Occasional and Mild    2= Occasional and Severe    3= Often and Mild    4= Often and Severe

	<b><u>Head</u></b>			<b><u>Heart, Lungs</u></b>	
0 1 2 3 4	Headache		0 1 2 3 4	Irregular Heart Beat	
0 1 2 3 4	Faintness		0 1 2 3 4	Rapid, Pounding Heart Beat	
0 1 2 3 4	Dizziness		0 1 2 3 4	Chest Pain	
0 1 2 3 4	Sleeplessness	___ Total	0 1 2 3 4	Chest Congestion	
			0 1 2 3 4	Asthma	
	<b><u>Eyes, Ears, Nose, Throat</u></b>		0 1 2 3 4	Bronchitis	
0 1 2 3 4	Stuffy Nose		0 1 2 3 4	Shortness of Breath	___ Total
0 1 2 3 4	Sinus Trouble				
0 1 2 3 4	Hay Fever			<b><u>Skin</u></b>	
0 1 2 3 4	Sneezing		0 1 2 3 4	Acne	
0 1 2 3 4	Nasal Congestion		0 1 2 3 4	Dry, Scaly Skin	
0 1 2 3 4	Swollen Eyes		0 1 2 3 4	Hair Loss	
0 1 2 3 4	Reddened Eyes		0 1 2 3 4	Excessive Sweating	
0 1 2 3 4	Watery, Itchy Eyes		0 1 2 3 4	Oily Skin	
0 1 2 3 4	Dark Circles Under Eyes		0 1 2 3 4	Hot Flashes	___ Total
0 1 2 3 4	Blurred Vision				
0 1 2 3 4	Earache, Ear Infection			<b><u>Digestion</u></b>	
0 1 2 3 4	Ringing in the Ears		0 1 2 3 4	Nausea, Vomiting	
0 1 2 3 4	Coughing		0 1 2 3 4	Diarrhea	
0 1 2 3 4	Sore Throat		0 1 2 3 4	Constipation	
0 1 2 3 4	Hoarseness, Loss of Voice		0 1 2 3 4	Heartburn	
0 1 2 3 4	Canker Sore		0 1 2 3 4	Stomach Pain	
0 1 2 3 4	Discolored Lips or Gums	___ Total	0 1 2 3 4	Bloating	
			0 1 2 3 4	Belching, Gas	___ Total
	<b><u>Memory, Emotions</u></b>				
0 1 2 3 4	Mood Swings			<b><u>Joints</u></b>	
0 1 2 3 4	Anxiety, Nervousness		0 1 2 3 4	Stiffness/Lack of Motion	
0 1 2 3 4	Anger, Irritability		0 1 2 3 4	Arthritis	
0 1 2 3 4	Aggressiveness		0 1 2 3 4	Pain in the Muscles	
0 1 2 3 4	Depression		0 1 2 3 4	Pain in the Joints	___ Total
0 1 2 3 4	Poor Memory				
0 1 2 3 4	Confusion			<b><u>Energy Levels</u></b>	
0 1 2 3 4	Lack of Concentration		0 1 2 3 4	Weakness	
0 1 2 3 4	Difficulty in Making Decisions		0 1 2 3 4	Fatigue	
0 1 2 3 4	Stuttering		0 1 2 3 4	Hyperactivity	
0 1 2 3 4	Slurred Speech		0 1 2 3 4	Restlessness	___ Total
0 1 2 3 4	Learning Disabilities	___ Total			
				<b><u>Weight</u></b>	
			0 1 2 3 4	Binge Eating/Drinking	
			0 1 2 3 4	Craving Certain Foods	
			0 1 2 3 4	Excessive Weight	
			0 1 2 3 4	Water Retention	
			0 1 2 3 4	Overweight	___ Total
				<b>Grand Total</b>	_____

## Signs and Symptoms of Oral/Facial Pain

### Check Below:

- ☐ HEADACHES
- ☐ JAW JOINT PAIN
- ☐ JAW JOINT NOISE OR CLICKING
- ☐ LIMITED MOUTH OPENING
- ☐ EAR CONGESTION
- ☐ DIZZINESS
- ☐ RINGING IN EARS
- ☐ DIFFICULTY SWALLOWING
- ☐ LOOSE TEETH
- ☐ CLENCHING OR GRINDING
- ☐ FACIAL PAIN
- ☐ SENSITIVE TEETH
- ☐ CHEWING DIFFICULTIES
- ☐ NECK PAIN
- ☐ POSTURAL PROBLEMS
- ☐ TINGLING IN FINGERTIPS
- ☐ HOT & COLD TEETH SENSITIVITY
- ☐ NERVOUSNESS OR INSOMNIA

### Head Pain, Headache

1. Forehead
2. Temples
3. "Migraine" type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

### Ear Problems

1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged, "itchy" ears
5. Vertigo, dizziness

### Eyes

1. Pain behind eyes
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

### Jaw Problems

1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw and/or tongue movements

### Mouth

1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't find bite

### Neck Problems

1. Lack of mobility, stiffness
2. Neck pain
3. Tired, sore muscles
4. Shoulder aches and backaches
5. Arm and finger numbness and/or pain

### Teeth

1. Clenching, grinding at night
2. Looseness and soreness of back teeth

### Throat

1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object in throat constantly

I verify that the information I have provided in this document is true and I give the doctor consent to treat me.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Emergency Contact

Printed Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Printed Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

## MESSAGE CANCELLATION POLICY

Massage therapy at Absolute Wellness is used for both relaxation and treatment in conjunction with chiropractic care. Due to the limited number of available appointment, we must enforce a cancellation policy.

Patients must provide no less than **24-hours notice** for cancelling a massage therapy appointment. If sufficient notice is not received, a **\$30 cancellation fee** will be charged at the patient's next office visit. This charge is the responsibility of the patient. Insurance will not be billed to cover this fee.

I, \_\_\_\_\_, understand that it is my responsibility to cancel massage appointments **24-hours** prior to my scheduled appointment. I understand that I will be charged and agree to pay a **\$30 cancellation fee** should I fail to do so.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## REHAB CANCELLATION POLICY

Rehab appointments at Absolute Wellness are intended to be part of a treatment plan along with chiropractic care. Failure to attend a scheduled rehab appointment may lengthen your recovery.

Patients must provide no less than **24-hours notice** for cancelling a rehab appointment. If sufficient notice is not received, a **\$30 cancellation fee** will be charged at the patient's next office visit. This charge is the responsibility of the patient. Insurance will not be billed to cover this fee.

I, \_\_\_\_\_, understand that it is my responsibility to cancel rehab appointments **24-hours** prior to my scheduled appointment. I understand that I will be charged and agree to pay a **\$30 cancellation fee** should I fail to do so.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, \_\_\_\_\_, hereby state that by signing this consent, I acknowledge and agree as follows:

\_\_\_\_ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

\_\_\_\_ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

\_\_\_\_ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:  
Postcards mailed to the addresses I have provided. Emails to the addresses I have provided.  
Calling, texting, leaving messages at the numbers I have provided or with the individual answering the phone.

\_\_\_\_ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

\_\_\_\_ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

\_\_\_\_ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

\_\_\_\_ 7. I give Absolute Wellness permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations

\_\_\_\_ 8. The doctor recommends that my spouse/partner/caretaker/guardian be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse/partner/caretaker/guardian contacts the office to check on my status.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Patient's Name Printed \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### TERMS OF ACCEPTANCE

When a patient seeks chiropractic 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 restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. 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.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at [www.chiropracticpeoria.net](http://www.chiropracticpeoria.net).

I have read and understand the information above.

Patient's Name Printed \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release any information deemed appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges occurred at this office.

I authorize and assign the direct payment to you of any sum I now or hereafter owe to your office by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.

I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.

In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Patient's Name Printed \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_