Your Wellness History

Date _____

greystone CHIROPRACTIC

Full Name _____ **Date of Birth** _____

Home Street Address _____

City, State, Zip _____

Cell phone _____ **Home or Work** _____

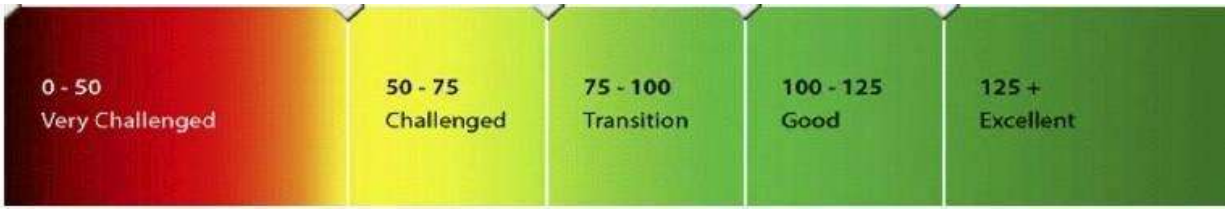
Email _____ **# Children** _____ **Ages:** _____

Occupation _____ **Hours/day on a computer** _____ **Hours/day sitting** ____

Rate your health and wellness:

Place an "X" where you believe your current level of health and wellness is

Place an "O" where you would like your health and wellness to be



Who can we thank for referring you to us? _____

What brings you to our office? (for wellness or no symptoms, please skip to "General History")

_____

_____

Describe the problem

_____

_____

1. **How long have you been experiencing this?**
2. **Rate the intensity from 1-10 with 10 being most severe**
3. **Where is it located**
4. **Do you know how it happened?**
5. **Is it constant or random?**

What makes it worse? _____

What makes it better? _____

Does this interfere with: Work ____ **Leisure** _____ **Sleep** _____ **Home life** _____ **Other** _____

Have you seen anyone else for this? Chiropractor _____ MD _____ Other _____

Who and when? _____

What was their diagnosis/recommendation? _____

General History

What ONE thing do you need to change to improve your health right now? _____

Medications? If yes, please list: _____

_____

Any injuries, accidents, or other trauma? _____

_____

Any surgeries or hospitalizations? _____

_____

Please check the following if they are current or have happened in the last 6 months:

❑ Headaches/migraines	❑ Digestive issues	❑ Eyes bothered by light
❑ Neck pain	❑ Menstrual difficulties	❑ Fainting
❑ Mid back pain	❑ Fertility issues	❑ Urinary issues
❑ Low back pain	❑ Ear issues	❑ Cold feet
❑ Pins/needles:arms/hands	❑ Gallbladder or liver issues	❑ Cold hands
❑ Pins/needles:legs/feet	❑ Ringing or buzzing in ears	❑ Prolonged diarrhea
❑ Dizziness	❑ Irritability/mood swings	❑ Ulcers
❑ Fatigue	❑ Depression	❑ Seizures
❑ Vertigo	❑ Thyroid issues	❑ Mental fog/concentration issues
❑ Allergies or Asthma	❑ Loss of smell or taste	❑ Autoimmune issues

Do you drink ½ your body weight in ounces of water daily? Yes No

Rate your level of stress(1-10, 10=severe):

Home: _____
Work: _____
Overall: _____

Would you like help with:

___ Nutritional advice
___ Stress management
___ Children's health

Office Policies

Consent for treatment, payment, and healthcare operations

I, _____ consent to the use of my Protected Health Information (PHI) by the doctor/s and/or staff of Birmingham Wellness LLC, d/b/a Greystone Chiropractic or (hereafter "the practice"), for the purpose of providing treatment for me, for purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations. Healthcare operations may include, but are not limited to: quality assessment activities, credentialing, business management, or general operational activities.

I understand the practice's diagnosis, treatment plan, and other evaluation and management information may be conditioned upon by consent as evidenced by my signature on this document. For purposes of consent, PHI means any information, including demographic information, created or received by the practice, that relates to my past, present or future physical or mental health or condition; the provision of healthcare to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However if the practice agrees to restriction I request, the restriction is binding on the practice until which time I remove the restriction in writing.

I understand that I have the right to review the practice's notice of privacy practice prior to signing this document. The notice of privacy practices describes my rights and the practice's duties regarding the types of uses and disclosures of my PHI. I have the right to revoke this consent, in writing, at any time, except to the extent that physician or the practice has acted in reliance on this consent.

I understand and agree that charges/fees for all services provided in this office are the patient's responsibility. Having an insurance policy does not guarantee their payment, even if the policy states that it covers services the practice renders to the patient. If you use your insurance in our office, we will do the necessary billing and communication with the insurance company to expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. In the event it becomes necessary for the practice or its members to employ collection or legal counsel, I understand and agree that I am responsible for payment of all collection charges, which will be added to my bill.

_____ _____

Patient or Responsible Party Signature Date

Assignment of Benefits:

I authorize the release of any medical or other information necessary to process an insurance claim on my behalf. I authorize payment of benefits to Birmingham Wellness, dba Greystone Chiropractic, for all services provided.

_____ _____

Patient or Responsible Party Signature Date

Insurance Company: _____

Informed Patient Consent & the Doctor-Patient Relationship

Chiropractic Care

It is the premise of chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis (balance and regulation). This allows the body to establish normal function, express appropriate adaptation as needed, and employ its recuperative, health-sustaining powers. The relationship between the spine and nervous system may affect the conduction of nerve impulses affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment, this allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes, and the physical and spinal conditions of each individual patient.

Chiropractic Analysis

The doctor will conduct a clinical analysis for the express purpose of detecting the presence of vertebral subluxation/s and the effects of those misalignments. If not detected, and the patient is in need of care from another provider, the patient will be informed and referred for other appropriate care.

Clinical Results

The purpose of chiropractic care is to promote health and vitality through the correction of the vertebral subluxation complex. Since there are many variables in healthcare, it is difficult to predict the timing, degree of response to care, and efficacy of chiropractic care for any given patient. However, the doctor may make recommendations for clinical management based on known circumstances and clinical experience. Due to complexities of nature, and the many variables, both known and unknown that can affect patient response to care, no doctor can promise specific results. The doctor of chiropractic (DC) is licensed to provide a specialized, unique, non-duplicating health service. The chiropractor is licensed in a special area of practice and is available to work alongside other providers in your healthcare regimen.

Medical Diagnosis

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the spine and body and their effects on the nervous system, they are not medical doctors, internists, or surgical specialists. Therefore, every patient should be mindful of their own condition/s and should secure other opinions should they have concerns as to the nature of any other symptoms or their total health picture. Your doctor of chiropractic may express an opinion as to whether or not further consult is necessary, but the patient is responsible for the final decision and any subsequent action.

Contraindications to Chiropractic Care

Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes adverse reactions. In rare cases, however, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures, or disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contraindicated. It is the responsibly of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of the doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.

Patient Consent

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 Informed Patient Consent and Doctor Patient Relationship. I hereby request and authorize the doctor to render chiropractic evaluation, and care if necessary.

_____ _____

Patient or Responsible Party Signature Date