The Wellness Way Flathead Valley
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PATIENT INFORMATION

Date ______________ First Name ________________ Middle Name __________ Last Name ________________

SSN ________________ Sex __________ Birth Date ______________ Height _____ Weight ____________

Marital Status _______________ Spouse Name ______________________________ Number of Children _____

Address ______________________________ City ________________ State ______ Zip _________

Home Phone ______________________________ Cell Phone ______________________________

Email ______________________________ Emergency Contact ______________________________

Emergency Relation ______________________________ Emergency Phone ______________________________

REFERRAL INFORMATION

I was referred by ____

How did you hear about the clinic?

☐ Advertisement ☐ Newspaper ☐ Community Event ☐ Provider Talk ☐ Family/Friend ☐ Other ______________

INSURANCE INFORMATION

Payment Options

***Please check one that applies.**

The Wellness Way – Flathead Valley *does not bill insurance directly with th exceptions of Medicare.* It is the patient's responsibility to check insurance coverage and submit claims to the insurance company. These claims are called "Superbills" and may be requested at the front desk. Should my account be referred for outside collection, I agree to pay all collection costs, attorney fees and court costs. A 1.25%monthly (15% APR) may be assessed in the unpaid balance of any and all of my accounts.

PATIENT PAY - Cash Check Visa MasterCard

Personal Injury (motor vehicle accident, etc.) – See above for directions on submitting claims.

MEDICARE

Medicare Claim/ID #::______________________________ Effective Date::____________________

Please present Medicare card at your first appointment.

EMPLOYER INFORMATION

Employed? Yes No Employer Name ______________________________

Occupation ____

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? ______________________________

Did something trigger your health changes?

Sleep

Average number of hours you sleep? ___________ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: ______________________

Injuries

Describe your injury and pain:

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _________ At its worst? __________ Now? ___________

Type of injury ______________________________

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other ______________________________

Injury Date ______________________ Have you missed work related to this injury? ◯ Yes ◯ No

Unable to work from (dates) ______________________ to ______________________

Received other treatment for this? ◯ Yes ◯ No Where or by whom? ______________________

X-rays taken? ◯ Yes ◯ No Do you currently receive chiropractic care? ◯ Yes ◯ No

What clinic or chiropractor provides that care? ______________________________

Tobacco/Alcohol

Currently using tobacco? ◯ Yes ◯ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ◯ Yes ◯ No

If yes, explain: ______________________________

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ◯ Yes ◯ No If yes, was it: ◯ Mild ◯ Moderate ◯ High

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Health History

Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox		
Measles		
Mumps		
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High Blood Pressure		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Other (describe)		

Injuries	Yes	No
Head Injury		
Neck Injury		
Back Injury		
Fracture		
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray			
Mammogram			
EKG			
Colonoscopy			
Upper GI Series			
Barium Enema			
CAT scan of abdomen			
CAT scan of brain			
CAT scan of spine			
Liver scan			
Bone scan			
Neck X-rays			
Back X-rays			
MRI			
Bone Density Test			
Blood Tests			
Other (describe)			

Operations	Yes	No
Tonsillectomy		
Tubes in Ears		
Appendectomy		
Gall Bladder		
Hernia		
Hysterectomy		
Dental Surgery		
Other (describe)		

Hospitalizations

When	For What Reason

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Women Specific

Check the box if yes and provide number.

❑ Pregnancies _____ ❑ Miscarriage _____ ❑ Living Children _____ ❑ Abortion _____ ❑ Cesarean _____

❑ Vaginal Delivery _____ ❑ Postpartum Depression _____ ❑ Toxemia _____ ❑ Baby Over 8 Pounds _____

❑ Gestational Diabetes _____

Menstrual History

Age At 1st Period _____ Menses Frequency ______________________ Length _________________________________

Painful? ◯ Yes ◯ No Clotting? ◯ Yes ◯ No Have you ever missed your period? ◯ Yes ◯ No

For how long? ________________________ Are you menopausal? ◯ Yes ◯ No Age At Menopause ______

Last Menstrual Period _________________________________

Do you take any hormone contraception? ❑ Birth Control Pill ❑ Patch ❑ Nuva Ring

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of **The Wellness Way - Flathead Valley** have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:______________________________

Signature: ____ Date: _________________________

TERMS OF ACCEPTANCE

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way-Flathead Valley. I authorize The Wellness Way-Flathead Valley and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize The Wellness Way-Flathead Valley to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Any scheduled appointment 30 minutes or longer must be canceled no later than 48 business hours prior to the appointment time. Any cancellations or missed appointments will result in a missed appointment fee. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I agree to the financial policy described above and will adhere to all of its practices.

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.
Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, ____ have read and fully understand the above statements.
(Print name)

I have read and understand the chiropractor's objective for my care in this office. I therefore accept treatment on this basis.

Signature: ____ **Date:** ____________________

CONSENT FOR X-RAYS

I authorize the Doctor to perform any radiographic studies that he/she deems necessary to diagnose and to administer treatment as needed for my present condition.

Signature: ____ **Date:** ____________________

CONSENT TO EVALUATE AND ADJUST A MINOR

I, ____________________________ being the parent or legal guardian of ____________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree, sign below.

Signature: ____ **Date:** ____________________

PATIENT HEALTH INFORMATION CONSENT

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. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, 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 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 with 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, 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, 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.

_______________________________________   ____________________

Signature of Patient   **Date**

IDENTIFICATION OF PERSONS WITH AUTHORIZATION OF ACCESS TO PATIENT HEALTH INFORMATION

Those individuals or parties that could have access to Patient Health Information at **The Wellness Way - Flathead Valley** include but may not be limited to the staff and contractors of The Wellness Way - Flathead Valley and the staff and contactors of The Wellness Way Clinics.

Please provide the necessary health care providers or persons who may need to be consulted if related to the patient's condition. They include:

1. ____
2. ____
3. ____
4. ____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

____ ____________________

Signature **Date**

FREQUENTLY ASKED QUESTIONS

Q: Are my appointments billable to insurance?

A: The Wellness Way – Flathead Valley does not bill insurance companies directly. It is the patient's responsibility to check insurance coverage and submit claims, (given to you by us), to the insurance company. These claims are called "Superbills" and may be requested at the front desk. Coverage depends on individual insurance policies. Full payment for services rendered is due at the end of each visit. We offer several different payment plans and will present these options in a financial consultation. Functional Medicine and nutrition services are not billable to insurance at this time.

Q: Will there be a potential for lab work?

A: Testing is a very important aspect that assists the doctor in determining the plan of care. If prior lab work has not been completed, the doctor may recommend specific tests during the report of findings visit. Lab prices vary depending on the recommended tests. Prices will be given to the patient at the time the labs are ordered by the doctor.

Q: Will I need supplements?

A: Supplements may be recommended to the patient during the test results visit. They are specific to the patient's individual needs. Supplements are used to support the body through the natural healing process. The doctor will instruct the patient on the dosage of each supplement as he/she deems necessary. Due to quality control supplements are non-refundable.

Q: What if I am only here for The Wellness Way Approach?

A: The first visit consists of a consultation, exam and any necessary x-rays. At the initial appointment the doctor will recommend tests for the patient. Once receiving the test results, the patient will be scheduled for a test results visit. This visit consists of an analysis of the test results, a binder with an individualized treatment plan, any necessary supplement schedules and a financial estimate.

Q: What if I am only here for Chiropractic?

A: The first visit consists of a consultation, exam, and any necessary x-rays. The following visit the doctor will go over a report of findings to discuss the results. At the 3rd appointment, the patient will receive a recommended plan of care as well as a financial estimate to start their chiropractic care.

We look forward to seeing you at your initial appointment! Feel free to contact the clinic with any further questions.