Thrive Wellness Center – A Wellness Way Affiliate
2766 Commerce Drive NW Suite C, Rochester, MN 55901
Phone: (507) 258-4100 | Fax: (507) 258-4101
rochester@twwclinics.com | TheWellnessWayClinics.com

APPLICATION FOR CARE AT THRIVE WELLNESS CENTER

Today's Date: __________ HRN: __________

PATIENT DEMOGRAPHICS

Name: ______________________________ **Birth Date:** ____-____-____ **Age:** ____ ☐ Male ☐ Female

Address: ____________________________ **City:** ____________________________ **State:** ______ **Zip:** _________

Email Address: __________________________ **Home Phone:** ________________ **Cell Phone:** ________________

Marital Status: ☐ Single ☐ Married **Do you have Insurance:** ☐ Yes ☐ No **Work Phone:** ________________

Current or Past Military: ☐ Yes ☐ No **If so, which branch of the military?** ______________________________

Employer: __________________________________ **Occupation:** _______________________________________

Spouse's Name: _____________________________ **Spouse's Employer:** ________________________________

Number of Children & Age: _______________________________

Name & Number of Emergency Contact: _____________________ _____________ **Relationship:** _______________

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: __________________________________
Secondarily: ________________________ Third: ________________________ Fourth: ________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **entering a number:**

Primary or chief complaint is
Secondary complaint is
Third complaint is
Fourth complaint is

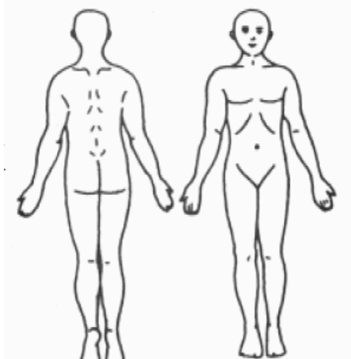
When did the problem(s) begin? ______________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It's constant **OR** ☐ It's on and off during the day **OR** ☐ It comes and goes throughout the week

How did this injury happen? ____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes, when:** ______ **By whom:** _____________

How long were you under care: _____________________ What were the results: _______________________________

Name of Previous Chiropractor: ______________________________ ☐ **N/A**



***PLEASE MARK** the ares on the Diagram with the following **letters** to describe you symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling

What relieves your symptoms? ______________________________________
What makes them feel worse? ______________________________________

Is your problem the result of **ANY** type of accident? ☐ Yes ☐ No

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
Example: *Sitting*	*I can only sit for 10 minutes*	*I can't sit as long as I want too*
_________________________:	______________________	______________________
_________________________:	______________________	______________________
_________________________:	______________________	______________________

***Whom may we thank for referring you to this office* ______________________________?**

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No **If yes** how many times? ___________
When was the last episode? _______________________ How did the injury happen? _______________________

Other forms of treatment tried? ☐ Yes ☐ No **If yes,** please state what type? ________________________________
Who provided it: ____ **How long ago:** ___________________
What were the results? ☐ Favorable ☐ Unfavorable **Please explain:** ___________________________________

____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

☐ Cancer ☐ Tumors ☐ Heart Disease ☐ Stroke ☐ Heart Attack ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes
☐ Thyroid Disease ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Kidney Disease ☐ Liver Disease ☐ Ulcers
☐ IBS ☐ Crohn's Disease ☐ Celiac's Disease ☐ Ulcerative Colitis ☐ Gall Bladder Problems ☐ Other Serious Conditions:

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. **Smoking:** ☐ Cigars ☐ Pipe ☐ Cigarettes : **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. **Alcoholic Beverage:** consumption occurs : ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. **Recreational Drug use:**
4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect the following. See pg 3: (Activities of Daily Living)

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
   If yes, whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Son(s) ☐ Daughter(s) ☐ Sister(s) ☐ Brother(s)
   Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know
2. Any other hereditary condition(s) the doctor should be aware of? ☐ No ☐ Yes: ___________________________

I hereby authorize payment to be made directly to Thrive Wellness Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thrive Wellness Center for any and all services I receive at this office.

________________________________ _____ - _____ - _____
Patient of Authorized Person's Signature **Date Completed**

________________________________ _____ - _____ - _____
Doctor's Signature **Date Form Received**

Patient's Name: ____________________________ **HR#:** ____________________ _____/_____/_____ **JDD, DC 2/2012**

ACTIVITIES OF DAILY LIVING / SYMPTOMS / MEDICATIONS

Patient Name: ____ **File#:** _______________
Date: _____________________

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition(s) is/are affecting you ability to carry out activities that are routinely part of your life.

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting or Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently Have and N for Never

___ Migraines	___ Pregnant (Now)	___ Dizziness	___ Trouble Sleeping or Sleep Apnea
___ Headaches	___ Convulsions/Epilepsy	___ Loss of Balance	___ Heartburn
___ Neck pain	___ Frequent Colds/Flu	___ Fainting	___ Asthma
___ Jaw pain, TMJ	___ Frequent Fevers	___ Vision Problems	___ Difficulty Breathing
___ Shoulder pain	___ Nausea	___ Ringing in Ear(s)	___ Lung Problem
___ Upper Back pain	___ Chest pain	___ Hearing Loss	___ Diarrhea/Constipation
___ Mid Back pain	___ Pain while Coughing or Sneezing	___ Loss of Smell	___ Prostate Problems
___ Low Back pain	___ Foot / Knee Problems	___ Depression	___ Impotence or Sexual Dysfunction
___ Hip pain	___ Sinus Problems	___ Irritable	___ Menopausal Problem
___ Back curvature	___ Swollen/Painful Joints	___ Mood Changes	___ Menstrual Problem
___ Scoliosis	___ Skin Problems	___ ADD/ADHD	___ PMS
___ Numbness/Tingling in Arms, Hands, Fingers		___ Allergies	___ Multiple Sclerosis
___ Numbness/Tingling in Legs, Feet, Toes		___ Eating Disorder	___ Hepatitis (A,B,C)

TRAUMA HISTORY

1. When was your most recent auto accident? ______________________________
   What speed was the collision? ______________________________
   Type of impact: Front impact / Side impact / Rear impact
   Was treatment(s) received? Please describe: ______________________________

2. When was your most recent strain / sprain / stress at work? ______________________________
   Please describe the manner of the injury: ______________________________
   Was treatment(s) received? Please describe: ______________________________
   Does your job require you to remain in long term stressful postures? ______________________________
   (i.e. all day sitting, repeated lifting, long term computer use)

List Prescription & Non-Prescription drug(s) you take:

____

____

____

____

Doctor's Signature: ______________________________ **Date:** ____________________ **JDD, DC 2/2012**

NOTICE OF PRIVACY PRACTICE

This office is required to notify you, in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or **as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to your. In addition, you will find we have placed several copied in report folders labeled **'HIPPA'** on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your **PHI**

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailing to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge via email, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like to have a disc of your images made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Thrive Wellness Center at (507) 258-4100. If we are unavailable, you may make an appointment with our office manager to discuss the concerns within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

Patient's initials: _______________

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my right or any of the information I have received.

Patient's Name ______________________ **DOB** __________ **HR#** __________

Patient's Signature ______________________ **Date** __________

Witness ______________________ **Date** __________

Page 2 of 2

THRIVE WELLNESS CENTER'S INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Thrive Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature ______________________ **Date** __________ **Witness' Initials** __________

X-RAYS/IMAGING STUDIES

FEMALES ONLY: please read carefully and check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

☐ The first day of my last menstrual cycle was on _____ / _____ / _____ date.

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature ______________________ **Date** __________ **Witness' Initials** __________

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any conditions other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: ________________________________ I have read and understand the above consent form