Central Park West Wellness

Welcome to Central Park West Wellness!

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health.

When a person seeks our care and when we accept a patient for such care, it is essential that we are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness.

Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care, and is necessary in emergency situations.

Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do in our office.

The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. The presence of vertebral subluxation complex is where the transmission of normal nerve impulses have been negatively affected by, and also causing loss of normal spinal biomechanics. These are referred to as subluxations. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information you provide on the following pages is vitally important. For this reason, please fill out our history forms completely and to the best of your ability so that we can

quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, ________________________________, have read the above, understand it.

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/way to contact you:	
Date of birth: / /	**Age:** **Social Security #:**
No. of children:	**Pregnant? Yes** □ **No** □
Height:	**Weight:**
Marital status: Married Single Widowed Divorced Partnered	**Spouse/Guardian name:**
Occupation:	
Employer's name & address:	
Name of person responsible for account:	
Do you have insurance? Yes ☐ **No** ☐ *If yes, please present your insurance card to us to copy*	
Plan Subscriber:	**Date of birth:** / /
Relationship:	
Subscriber ID number:	**Plan ID number:**

Who may we thank for referring you?
____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the ***"General Health History"****.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did the most current episode start?	When was the first time you **EVER** recall having this problem?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?
____
____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐
What have you done for this condition? Was it of benefit?

____

____

I do (do not) have a family history of this or similar symptoms (Please explain):

____

____

Which activities aggravate your condition ☐ Sitting ☐ Standing ☐ Changing Position ☐ Walking ☐ Bending ☐ Lifting/Twisting

☐ Driving ☐ Sneezing/Coughing ☐ Computer Work ☐
Other:____

Other providers you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Acupuncturist	☐
Physical Therapist or Other (please describe)	☐

Primary Care Doctor's details:

Name:	Address:
When did you last see them?	Date of last blood work:
What did they say was wrong?	
Did it help?	What did they do?

Specialist's details:

Name:	Address:
When did you last see them?	Date of last blood work or testing:
What did they say was wrong?	
Did it help?	What did they do?

General Health History

Accumulation of life's stress can lead to health problems and influence our ability to heal. Please fill out fully - it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays, MRIs, CT scans, DEXA (bone density) scans taken or EMG/NCV performed?

Area of body:	When?	Where?
Area of body:	When?	Where?
Area of body:	When?	Where?

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

What do you do most of the day in your job postures, positions, and repetitive movements:

____
____
____
____

Current Medicines and Supplements

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____

____

____

____

____

Past Health History

Please mark the following conditions. **Mark an "N"** for conditions you have NOW. **Mark a "P"** for those you have had in the PAST.

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)

☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain):____

____

____

Stressors

Every trauma (slips, falls, accidents, injuries, emotional traumas, ect.) large or small affects our spine and nervous system in some way. Please give a brief description of any significant injuries or accidents over the course of your life, whether or not you think they are related to your spine:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____
   a. ____
   a. ____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   a. ____
   a. ____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____

a. ____

a. ____

On a scale of 1-10 with 1=Poor and 10=Excellent, please grade how well you think you are doing in the following categories:

Exercise:	Energy level:	Diet:	Stress Level:	Sleep:

Is there anything else which may help to better understand you which have not been discussed?
____
____
____
____

On a scale of 1-10, with 10 being the highest, rate your level of commitment to resolving this problem:
____

Please list any concerns you may have about getting this problem corrected:
____
____
____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ Date: _____________________

Signature: ____

Please initial after each statement.

I recognize and accept complete financial responsibility for any balance remaining after the payment of any correct benefits by an insurance company. If an unpaid balance remains, I agree to pay reasonable costs and expenses of collections.______

I understand that nutritional supplements that are sold in this office will not be billed to my insurance company. I understand that rehabilitation materials are my sole financial responsibility and will not be released without payment. _______

When applicable, I assign insurance benefits for all services rendered by permitting payment directly to Central Park West Wellness, for services rendered. _______

Payment is accepted by cash, check, and/or credit card. There will be up to a $50 charge for returned checks._____

I declare under penalty of perjury (under the laws of the United States of America that the foregoing is true and correct: *I am not attempting to investigate Central Park West Wellness as a representative of any agent or entity, or any insurance company or organizational entity or person.* ________

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient ________________________________Date______________

Signature of Patient and/or Legal Guardian____________________________________

Policies & Procedures

Authorization for Medical Information Release

I authorize Central Park West Wellness to furnish my insurance company with medical information they may request regarding my condition or treatment. I authorize all of my health care providers to release any treatment notes, diagnostic reports and/or surgery reports to Central Park West Wellness. Furthermore, I authorize Central Park West Wellness to release any treatment reports to a referring and/or co-treating physician as it corresponds with my chiropractic care. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Central Park West Wellness will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. Images that identify me will be released and/or used outside the practice only upon written authorization from me or my legal representative.

Printed Name of Patient ________________________________Date______________

Signature of Patient and/or Legal Guardian__________________________________

Privacy Notice & Patient Bill of Rights (*HIPAA form viewable on website and physical copy available review in our office)*

I have read and understand the Central Park West Wellness Notice of Privacy Practices and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Designated persons to aid in patient care or to communicate medical information:

Name: _________________________ Relationship: __________________________

Name: _________________________ Relationship: __________________________

Printed Name of Patient ________________________________Date______________

Signature of Patient and/or Legal Guardian__________________________________