



**HEALTH HISTORY**

Have you ever seen a Doctor of Chiropractic before?  Y  N Who? \_\_\_\_\_

List other Doctors you have seen for this condition:

Who: \_\_\_\_\_ Address \_\_\_\_\_ When: \_\_\_\_\_  
Who: \_\_\_\_\_ Address \_\_\_\_\_ When: \_\_\_\_\_

What treatment have you received for this condition?

Medication  Physical Therapy  Chiropractic Services  Surgery  Other: \_\_\_\_\_

Who is your family Physician? \_\_\_\_\_ address \_\_\_\_\_ Phone \_\_\_\_\_

May we Send him/her an update on your treatment in our office? Y N

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Blood Test \_\_\_\_\_ Urine Test \_\_\_\_\_  
Spinal Exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ MRI,CT,Bone Scan \_\_\_\_\_ OB/GYN Exam \_\_\_\_\_

**PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD IN THE LAST MONTH**

Balance Impairment      Headaches      Memory Loss      Dizziness      Nausea      Nervousness  
Sleeplessness      Chest Pains      Ringing in Ears      Lightheaded      Visual/Sensory Disturbance  
PMS/Menstrual pain      Jaw Pain      Loss of Concentration

List any abdominal complaints(gas, pain, etc) \_\_\_\_\_

List any respiratory complaints(coughing, congestion, difficulty breathing, etc) \_\_\_\_\_

List any cardiac complaints(arm pain, chest pain, shortness of breath etc) \_\_\_\_\_

List any reproductive /Urinary complaints(abnormalities, pain, etc) \_\_\_\_\_

**PLEASE CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE EVER HAD**

AIDS/HIV      Cataracts      Herniated Disk      Parkinsons      Tuberculosis  
Anemia      Chemical Dependency      Herpes      Pinched Nerve      Tumors  
Anorexia      Diabetes      High Blood Pressure      Pneumonia      Ulcers  
Appendicitis      Emphysema      Hi Cholesterol      Polio      Varicose Veins  
Arthritis      Epilepsy      Jaw/TMJ Pain      Prosthesis Whiplash      Fatigue  
Asthma      Glaucoma      Kidney Problem      Psychiatric Care      Other: \_\_\_\_\_  
Blood Clots      Goiter      Liver Disease      Rheumatoid Arthritis      \_\_\_\_\_  
Breast Lump      Gout      Mononucleosis      Rheumatic Fever      \_\_\_\_\_  
Bronchitis      Heart Disease      Multiple Sclerosis      Scarlet Fever      \_\_\_\_\_  
Bulimia      Hepatitis      Osteoporosis      Stroke      \_\_\_\_\_  
Cancer      Hernia      Pacemaker      Thyroid Problem      \_\_\_\_\_

INJURIES AND SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
Accidents/Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

**PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING**

Medication/Supplement \_\_\_\_\_ For \_\_\_\_\_  
Medication/Supplement \_\_\_\_\_ For \_\_\_\_\_  
Medication/Supplement \_\_\_\_\_ For \_\_\_\_\_

LIST ANY ALLERGIES: \_\_\_\_\_

LIST ANY DISEASES/ILLNESSES THAT RUN IN THE FAMILY \_\_\_\_\_

**SOCIAL HISTORY**

Are you Pregnant?  Y  N  Unsure Due Date \_\_\_\_\_ OB/GYN: \_\_\_\_\_

Indicate Exercise Level:    None      Moderate      Daily      Heavy

**Indicate any Work activities that Apply:**

Long term Sitting      Long Term Standing      Repetitive Motions      Heavy Labor      Light Labor

**Indicate any Lifestyle/Habits you have:**

\_\_\_ Smoking: \_\_\_ Packs/Day      \_\_\_ Coffee/Sodas/Caffeine: \_\_\_ Cups/Day  
\_\_\_ Alcoholic Beverages \_\_\_ Drinks/Day      \_\_\_ High Stress Level : Reason \_\_\_\_\_  
\_\_\_ Poor Diet/High salt,fat,or sugar intake

Please list your Hobbies and recreation activities: \_\_\_\_\_

I understand that Completion of a History and exam does not mean that I have been accepted as a patient. It will be decided based on the history and exam whether I can be accepted as a patient. Fees will still be due for the exam even if I cannot be accepted as a patient.

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

FINANCIAL POLICY – PAYMENTS TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a payer and/or representative may tell us, including mis-quoted benefits, coverage and liability.

1. **Our Facility will file initial insurance claims for you. Secondary claim submission and /or additional reports or documents sent for your benefit may result in an additional filing medical report charge, which you are responsible to pay.**
2. **Co-pays, deductibles and all non-covered service charges are due the day the service is rendered and are the patient's sole responsibility.**
3. **Patients are responsible for charges on all service(s) and/or product(s) which 1) are non-covered (regardless of in our out of network status) or 2) may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet the cost of service.**
4. **All account balances, including automobile claims must be paid within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, and judgment. If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.**
5. **A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, or massage therapy.**
6. **The Facility offers the use of Care Credit to patients preferring to use a credit type payment plan. Any agreement made is between Care Credit and the Patient. Patient is responsible for any and all charges for services rendered.**
7. **A service charge is computed by a periodic rate of 1 ½ % per month- 18% per annum & is added to all balances owed 60 + days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees.**
8. **Missed appointments that are not canceled at least 24 hours prior to appointment time will be subjected to a Missed Appointment Fee at the Office's discretion. The Fee will be the patient's sole responsibility.**
9. **Patient consents to use of cell phone as a contact when necessary for any and all purposes including, but not limited to communication about care or accounts, collection calls, appointment reminders, etc.**
10. **If your Insurance does not pay within 60 days of the service date, the patient becomes responsible for the FULL amount owed on that service date, REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC. Any credit that results from future payments by insurance company will be applied to patient account, and a refund check will be issued at patient request.**
11. **If the patient at any point during the treatment plan discontinues care, voluntarily or involuntarily, their balance IN FULL of rendered care becomes immediately due REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC.**
12. **Checks drawing on insufficient funds, closed account, stop payments or other reasons of non-payment will be assessed a \$30 fee. If the fee and original check amount are not paid to the office in a reasonable amount of time after notification, the matter will be turned over to the County or district attorney.**

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document and fully understand and have all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

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Print Name of Patient

Signature (if minor, parent must sign)

Date

**Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)**

In this document, "I" and "my" refer to the patient; "Chiropractor" refers to Dr. Heather Wright, BS, DC, CCEP.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restricts, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**PERSONAL INFORMATION CAN BE GIVEN ONLY TO THOSE YOU LIST**

1. Please list the **name** and **relation** and **phone number** of any person(s), if any, whom we may inform about your general medical condition, your diagnosis, prognosis **AND APPOINTMENTS**. (i.e. spouse, sibling, school nurse, or other.)

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2. Please list the **name** and **home number**, if any to whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

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2. If other than your home address, please print the primary address of where you would like all correspondence from our office sent. \_\_\_\_\_
3. If other than you home phone number, please print the telephone number of where you want to receive calls about your appointments, lab and x-ray results or other health care information. \_\_\_\_\_
4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" \_\_\_\_\_
5. **Appointment reminders may be texted to you. Please indicate if you do not want us to text your appointment reminders. Please inform the front desk in writing when turning in paperwork.**

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By my signature below I give Wright Chiropractic permission to contact me, and/or leave me messages using any of my contact information collected in my paperwork unless specifically excluded here: **Do not contact me at:** \_\_\_\_\_

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\_\_\_\_\_  
Signature of Patient /Representative                      Printed Name of Patient                      Date

**INFORMED CONSENT**  
**Wright Chiropractic Health Center, PA**  
**702B Eureka St**  
**Weatherford, TX 76086**

PATIENT NAME \_\_\_\_\_

The primary treatment used by doctors of chiropractic is the spinal manipulation, also called spinal adjustments. Extremity adjustments may also be performed if your case warrants.

◆ **The nature of the chiropractic adjustment.**

The doctor will use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

◆ **This is a multi-doctor office.**

This is a multiple doctor office. While you will have a primary provider who sees you the most, you will on occasion be seen by a different doctor in the office or if appropriate, transferred to one of the other doctors in the office. By signing this consent, you are agreeing to this and understand.

◆ **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, nausea, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

◆ **The probability of those risks occurring.**

Muscle soreness, tightness, and general discomfort is the most common reaction to the adjustments, especially in the beginning of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

◆ **Ancillary treatments.**

In addition to chiropractic adjustments, the Doctor may use additional following treatments:

Electrical Muscle Stim

Ice Therapy

Heat Therapy

Ultrasound/Iontophoresis

Cold Laser Therapy

Traction

Kinesiotaping

Flexion/Distracton

Nutritional Counseling/Supplements

Massage

Exercise and Stretching Rehab

Balance and Proprioception Training

These treatments involve the following additional significant risks:

Potential Burns, injuries from falls/loss of balance, muscle injuries, frostbite

◆ **The availability and nature of other treatment options.**

Other treatment options for your condition will be discussed in your Report of Findings and may include (but are not limited to:)

- ◆ Self-administered, over-the-counter analgesics and rest
- ◆ Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers. Physical Therapy
- ◆ Hospitalization with traction Massage
- ◆ Surgery

◆ **The material risks inherent in such options and the probability of such risks occurring include:**

- ◆ Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
- ◆ Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
- ◆ Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
- ◆ The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

◆ **The risks and dangers attendant to remaining untreated.**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high. Eventual Surgery May arise from lack of treatment or failure to follow-through with recommendations.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Heather Wright and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

\_\_\_\_\_  
DATE

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## **General Oswestry Disability Index**

*everyone must complete*

### **Section 1 – Pain Intensity**

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### **Section 2 – Personal Care (washing, dressing, etc.)**

- I can look after myself normally.
- I can look after myself normally but it is slightly painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

### **Section 3 - Lifting**

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### **Section 4 – Walking**

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### **Section 5 – Sitting**

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.

- Pain prevents me from sitting at all.

### **Section 6 – Standing**

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### **Section 7 – Sleeping**

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### **Section 8 – Sex life (if applicable)**

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### **Section 9 – Social Life**

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

### **Section 10 – Traveling**

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

### **Section 11 - Previous Treatment**

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

## **Neck Oswestry Disability Index**

*everyone must complete*

### **Section 1 – Pain Intensity**

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

### **Section 2 – Personal Care (Washing, Dressing, etc.)**

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

### **Section 3 – Lifting**

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

### **Section 4 – Reading**

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

### **Section 5 – Headaches**

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

### **Section 6 – Concentration**

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

### **Section 7 – Work**

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

### **Section 8 – Driving**

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

### **Section 9 – Sleeping**

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

### **Section 10 – Recreation**

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)



## George's Test

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the correct response, and sign and date when completed.

Have you ever been diagnosed or told you have any of the following?

- |  |     |    |
|--|-----|----|
| 1. High Blood Pressure (hypertension)                    | Yes | No |
| 2. Hardening of the arteries (arteriosclerosis)          | Yes | No |
| 3. Diabetes  | Yes | No |
| 4. Heart or Blood Vessel disease                         | Yes | No |
| 5. Bone spurs in your neck (cervical spondylosis)        | Yes | No |
| 6. Whiplash injury or cervical sprain                    | Yes | No |
| 7. Have any of your blood relatives suffered a stroke?   | Yes | No |
| If yes, WHO: _____                                       |     |    |
| 8. Were you ever a smoker? From _____ to _____           | Yes | No |
| 9. Do you take any medication on a regular basis?        | Yes | No |
| What?(Cumadin, heparin, aspirin, anti-hypertension, etc) |     |    |
| SAME AS INTAKE or: _____                                 |     |    |
| 10. For Women: Have you ever taken oral contraceptives?  | Yes | No |
| From _____ to _____                                      |     |    |

Have you had any of the following, even short, temporary attacks **in the last year?**

- |  |     |    |
|--|-----|----|
| 11. Blurred Vision   | Yes | No |
| 12. Double Vision  | Yes | No |
| 13. Diminished or partial loss of vision in one or both eyes                               | Yes | No |
| 14. Complete loss of vision in one or both eyes  | Yes | No |
| 15. Ringing, buzzing, or unusual noise in the ear(s)                                       | Yes | No |
| 16. Hearing loss in one or both ears   | Yes | No |
| 17. Slurred speech or other such speech problems   | Yes | No |
| 18. Difficulty swallowing  | Yes | No |
| 19. Dizziness  | Yes | No |
| 20. Temporary lack of understanding  | Yes | No |
| 21. Loss of consciousness, even momentary blackouts  | Yes | No |
| 22. Numbness or loss of sensation in your face, hands, feet<br>or other parts of your body | Yes | No |
| 23. Any other abnormal sensations in your body   | Yes | No |
| 24. Weakness, clumsiness or loss of strength in any body part                              | Yes | No |
| 25. Sudden collapse without loss of consciousness?   | Yes | No |

**Patient Signature**

**Date**

**DOCTOR'S NOTES** Hypertension & Subclavian Artery Stenosis/Occlusion (seated)

1. Record the blood pressure : LEFT \_\_\_/\_\_\_ RIGHT \_\_\_/\_\_\_ see exam

- |   |     |    |
|---|-----|----|
| 2. Is this indicative of hypertension?  | Yes | No |
| 3. Is there >10 mmHg difference b/w arms  | Yes | No |
| 4. Is the radial artery on the low side feeble or unpalpable  | Yes | No |
| 5. Is there a bruit over the subclavian artery either side (if bruit then poss vasc consult before other procedures)<br>(if bruit then poss vasc consult before other procedures) | Yes | No |

**Carotid artery Stenosis/Occlusion**

- |  |     |    |
|--|-----|----|
| 6. Is there a bruit over either Carotid bifurcation              | Yes | No |
| 7. Is either bifurcation feeble or absent palpably comparatively | Yes | No |

(If either stenosis or occlusion is suspected, do not due the last maneuver)

**Vertebro-Basilar Artery Functional Maneuver**

Have the patient do full rotation and hyperextension, counting down from 20. Bilateral.

Did any of the following occur: Slurred speech, nystagmus, dizziness, faintness, blurred vision, etc

Examiner's Initials \_\_\_\_\_

Date \_\_\_\_\_

symptom was: \_\_\_\_\_ while in position or when coming back from position

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## Wright Chiropractic Health Center Patient Privacy Rights- Patient Information

Patient information will remain completely confidential and will never be sold. Patient information obtained in permanent records will be used solely for the business of Wright Chiropractic Health Care. Any disposal of records will be done in such a manner that the information contained within will be illegible and unobtainable to other parties. This will include any or all of the following: shredding, incineration, and silver recovery. Use of Patient information for marketing will not occur without your written permission, excluding any face-to-face disclosures or community service promotions.

While every attempt to protect your information will be made, overheard communications in the office may be unavoidable. Calling your name in the waiting room and sending mail to your house are all considered routine and normal disclosures.

Non-routine disclosures of patient information will not be released without a written valid authorization by the patient. This includes release of any information to family, friends, attorneys, insurances that are not the patient's health insurance company, and any other such release.

You have the following rights with your Protected Health Information (PHI) :

- 1) The right to have access to, review, and request changes of errors to your health records
- 2) The right to obtain a copy of these records at a reasonable cost incorporating the supplies and labor of copying and postage (if applicable.)
- 3) The right to protest procedures you feel are not protecting your PHI and submit a complaint to Dr. Wright, the privacy director.
- 4) In the case of an independent minor, the health care provider will use her discretion to approve or deny access of the minor's records to a parent.
- 5) For non-routine use or information disclosure, the patient will have to grant written permission. Routine releases of information that would not require express patient permission includes all activities to carry out treatment, payment, or health care operations.
- 6) The right to object to specific disclosure by Wright Chiropractic.
- 7) The right to receive notice of how your PHI will be used by Wright Chiropractic Health Center
- 8) The right to receive information by an alternative means. This office will use your home address and phone number and occasionally your work number, all provided by you on your intake form, to issue reminders and correspondence. Should you desire not to be contacted using that information, you may provide an alternative way for the office to contact you. In the case of an emergency, your emergency contact will be used.
- 9) The right to receive an accounting for all disclosures by this office
- 10) The right to file a formal complaint with the Secretary of the  
Department of Health & Human Services concerning any breach of these rights.