Wright Chiropractic Health Center

Young Child Patient Information and History

PATIENT INFORMATION

ID #(office use)____

Date:_____

Name_____

Last First Middle

Parent's Name:_____

Address_____

_____

Sex: __M __F Age:____ Birth Date_____

Social Security #_____

Parent's SS#_____

Who may we thank for referring you?

_____

CONTACT INFORMATION

Home_____ Work_____

Cell_____

Parent's Email:_____

In case of an emergency, contact:

Name_____

Relationship_____Number_____

SOCIAL HISTORY

Indicate Exercise Level: None Moderate Daily Heavy

Indicate any Lifestyle/Habits child has:

___Coffee/Sodas/Caffeine: ____Cups/Day

___High Stress Level :

Reason_____

___Poor Diet/High salt,fat,or sugar intake

Please list child's Hobbies and recreation activities:_____

Primary Doctor:_____

Phone:_____ City:_____

.

OTHER DOCTORS CONSULTED:

Name_____

Specialty_____

Location_____

Name_____

Specialty_____

Location:

PATIENT CONDITION (ALL QUESTIONS SHOULD BE ANSWERED)

Reason For this visit (if this is for a wellness check , then disregard the following questions and mark "N/A" in answers)

_____

When did the symptoms first appear_____

Cause_____

Was onset: __Gradual __Sudden

Is it getting worse? __Y __N

How often do you experience Symptoms?

__Constant (100%) __Frequent (75%) __Intermittent(50%)

__Occassional(25%) __Rare (10% or less)

Type of Pain: __Sharp __Dull __Throb __Numb __Ache

__Shooting __burning __Tingle __Cramp __Stiff __other

Where does it radiate to?_____

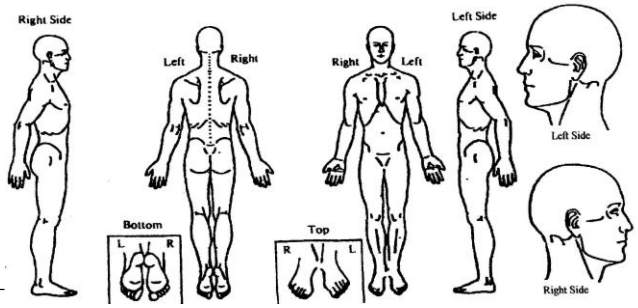
What gives relief?_____

What makes it worse?_____

Does it interfere with:__Work __Daily Activities __Sleep

Rate the pain from 0 (no pain) to 10 (worst pain felt) _____

PLEASE MARK ALL AREAS OF PAIN (INCLUDING ANY RADIATIONS) ON THE FIGURE BELOW



OTHER TREATMENT CHILD HAS RECEIVED FOR THIS CONDITION:

__Medication ___Physical Therapy __Surgery ____Other:_____

PLEASE CIRCLE ANY SYMPTOMS CHILD HAS 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)_____

INJURIES & SURGERIES CHILD HAS HAD	**DESCRIPTION**	**DATE**
Accidents/Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

PLEASE CIRCLE ANY SYMPTOMS YOUR CHILD CURRENTLY HAS OR HAS 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
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	_____

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_____

FINANCIAL INFORMATION:

Primary Insurance _____
Subscriber's Name_____
Subscribers SS#_____DOB_____
Relationship to Patient_____

Secondary Insurance_____

Assignment and Release

I authorize that payment of insurance benefits be made on my behalf to Dr. Heather Wright, DC/Wright Chiropractic Health Center for any services rendered to me. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other Health Insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on approved claim forms or electronic claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that this provider may not be preferred provider. Coinsurance and the deductible are based upon the charge determination of the carrier.
I understand that completion of a consultation and/or an exam does not imply that my child has been accepted as a patient. Fees for services rendered are due even if a doctor-patient relationship is not established.

_____ _____
Patient/Guardian's Signature Date

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
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) _____		
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 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 ____/_____

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 on unpalpable	Yes	No
5. Is there a bruit over the subclavian artery either side (if bruit then poss vasc consult before other procedures)	Yes	No
(if bruit then poss vasc consult before other procedures)		

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 Yes No

_____ _____

Examiner's Initials Date

INSURANCE BENEFITS – 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.
3. Patients are responsible for charges on all service(s) and/or product(s) which 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, psychological counseling services and massage therapy.
6. 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. Returned checks charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $25.00 charge.
7. Note: 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.

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.

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 form 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.)

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

_____

_____

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 "**CONFIDENTAL"**

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:_____

_____ _____ _____

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, sometimes called spinal adjustment. Extremity sdjustments 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.

- **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 treatment.**
  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/Distraction
  Nutritional Counsleing
  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 were 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.
- Hospitalization with traction
- 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)

Wright Chiropractic Health Center
702B Eureka St
Weatherford, TX 76086
817-594-5944

I give permission for the following people to sign paperwork for my child, _____, when I am not present:

1)

2)

3)

4)

Legal Guardian:_____
Signature Printed

Date:_____