

Comprehensive Health History

Patient Information

Patient Name: _____
(last) (first) (middle initial)

Address: _____

City: _____ State _____ Zip _____

Home Ph: (____) _____ Cell Ph: (____) _____

Work Ph: (____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#: _____ DOB: _____ Age: _____

Status : Single Married Widowed Divorced Separated Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (____) _____ Cell Ph: (____) _____

How Did You Hear About Us?

- Referral: _____ Direct Mail
 Internet Magazine
 TV Other: _____

Insurance Information

Who is responsible for this account? Self Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? Yes No

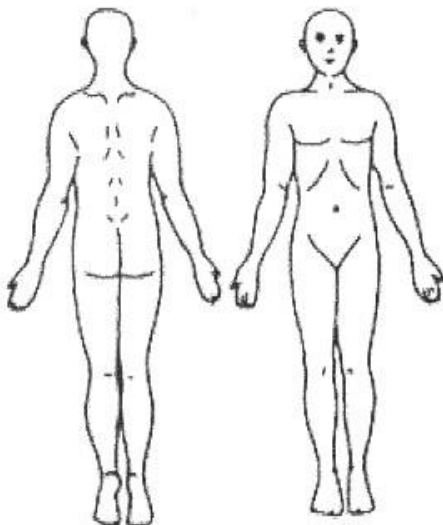
Subscribers Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

Insurance Company: _____

Policy # _____ Group # _____



Label on the Diagram the CURRENT Areas of Discomfort:

- A= Aching
- B= Burning
- C= Cramps
- D= Dull
- N= Numbness
- P= Pins&Needles
- S= Stabbing
- SH= Sharp
- ST= Stiffness
- SW= Swelling
- T= Tingling

Current Condition

If you could erase 3 health problems, what would they be?

1. _____
2. _____
3. _____

Problem #1

When did you 1st notice this problem? _____

Has it occurred before? Yes No When? _____

Is the condition getting worse? Yes No Unknown

Is the Condition: Auto Related Job Related Home Injury
 Slip/Fall Lifting Slept Wrong Unknown Cause
 Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: Work Sleep Daily Routine Recreation

What treatment have you received for this problem?

Medication Surgery Physical Therapy Chiropractic Services
 None Other _____

Problem #2

When did you 1st notice this problem? _____

Has it occurred before? Yes No When? _____

Is the condition getting worse? Yes No Unknown

Is the Condition: Auto Related Job Related Home Injury
 Slip/Fall Lifting Slept Wrong Unknown Cause
 Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: Work Sleep Daily Routine Recreation

What treatment have you received for this problem?

Medication Surgery Physical Therapy Chiropractic Services
 None Other _____

Problem #3

When did you 1st notice this problem? _____

Has it occurred before? Yes No When? _____

Is the condition getting worse? Yes No Unknown

Is the Condition: Auto Related Job Related Home Injury
 Slip/Fall Lifting Slept Wrong Unknown Cause
 Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: Work Sleep Daily Routine Recreation

What treatment have you received for this problem?

Medication Surgery Physical Therapy Chiropractic Services
 None Other _____

If Auto or Job Related:

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp Other _____

Attorney Name: (if applicable) _____

Current Medications

Medication Dosage/How Long For What Condition?

Medication Allergies: _____

Reaction? _____

Supplement Allergies: _____

Reaction? _____

Food Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc*)

Yes No If yes, where located _____

Have your medications or supplements ever caused you unusual side effects or problems? Yes No Describe: _____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? Yes No

Tylenol? Yes No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? Yes No

Frequent Antibiotics (> 3 times a year) Yes No

Long Term Antibiotics Yes No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) Yes No

Work Activity

Labor Activity:

Light Moderate Heavy Sedentary

Work Activity Postures:

Bending Climbing Kneeling Pulling
 Pushing Reaching Sitting Standing
 Twisting Walking Computer Repetitive

Work Activity Level:

Full-Time Part-Time Homemaker Student Unemployed

Hours per week _____ Mostly Sitting Walking Standing

Work Environment:

Difficult Enjoyable Relaxed Stressful

Lifestyle History

Check Your Exercise Levels:

- Inactive** – no regular physical activity with a sit-down job.
 Light Activity – no organized physical activity during leisure time.
 Moderate Activity – occasionally involved in activities (2-3x/week)
 Heavy Activity – consistent lifting, stair climbing, heavy construction, etc., or regular participation in active sports. (3-5x/week)
 Vigorous Activity – participation in extensive physical exercise for at least 60 minutes per session (4-7x/week)

Please check all that apply:

Tobacco – Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? _____

Alcohol _____ Drinks/Week: _____

Coffee/Caffeine Drinks _____ Cups/Day: _____

Do you currently or have previously used recreational drugs? Yes No

If yes, what types/method (IV, inhaled, smoked, etc) _____

Allergies

Do you have a history of allergies? Y N

If so for how long? _____

What season(s) do your allergies bother you the most?

Spring Summer Fall Winter All Year

Common Allergy Symptoms: Please rate by severity

0=None 1=Mild 2=Moderate/Severe

Nasal Congestion	0	1	2
Sneezing	0	1	2
Coughing	0	1	2
Wheezing	0	1	2
Asthma	0	1	2
Watery, Itchy Eyes	0	1	2
Sinus or Ear Infections	0	1	2
Sore Throat	0	1	2
Trouble Breathing while sleeping	0	1	2
Fatigue	0	1	2
Headaches	0	1	2
Itchy Skin	0	1	2
Eczema	0	1	2
Hives	0	1	2

Do you have a history of heart disease? Y N

Do you have a history of asthma or lung disease? Y N

Have you ever been to an emergency room, urgent care or hospital due to an allergic reaction? Y N

Please list any know allergies and the symptoms they cause:

Patient Name _____ Patient Signature _____ Date _____

Medical History

Please check all that apply / Indicate When and any Comments/Results

Surgeries (Indicate what year)

<input type="checkbox"/> N/A	_____	<input type="checkbox"/> None Reported	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Bunionectomy	_____
<input type="checkbox"/> Cardiac Bypass	_____	<input type="checkbox"/> Cataracts	_____
<input type="checkbox"/> C-Section	_____	<input type="checkbox"/> Carpal Tunnel	_____
<input type="checkbox"/> Cosmetic	_____	<input type="checkbox"/> Ear Tubes	_____
<input type="checkbox"/> Gall Bladder	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Implants	_____	<input type="checkbox"/> Knee	_____
<input type="checkbox"/> Lasik	_____	<input type="checkbox"/> Spinal Fusion	_____
<input type="checkbox"/> Tonsillectomy	_____	<input type="checkbox"/> Wisdom Discectomy	_____

Injuries

<input type="checkbox"/> Back Injury	_____	<input type="checkbox"/> Broken Bones/Fractures	_____
<input type="checkbox"/> Head Injury	_____	<input type="checkbox"/> Industrial	_____
<input type="checkbox"/> Neck Injury	_____	<input type="checkbox"/> Severe Fall	_____
<input type="checkbox"/> Soft Tissue	_____	<input type="checkbox"/> Other	_____

Medical History - Past or Present Illnesses

Please check all that apply (past or present) / Circle **CURRENT** Conditions

<input type="checkbox"/> ADD	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergies
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Atopic Dermatitis	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cholera	<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> CRPS (RSD)
<input type="checkbox"/> Constipation	<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> Cystic Kidney Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes (<i>insulin</i>)	<input type="checkbox"/> Diabetes (<i>non insulin</i>)	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Fetal Drug Exposure	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Gallbladder Disorder
<input type="checkbox"/> Gallstones	<input type="checkbox"/> German Measles	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia
<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Herpes/Lesions/Shingles	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypoglycemic	<input type="checkbox"/> Influenza Pneumonia
<input type="checkbox"/> IBS (<i>Irritable Bowel Syndrome</i>)	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Lupus Erythema (<i>Discoid</i>)	<input type="checkbox"/> Lupus Erythema (Systemic)	<input type="checkbox"/> Malaria
<input type="checkbox"/> Measles	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Nervous Breakdown	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> STD	<input type="checkbox"/> Stroke	<input type="checkbox"/> Suicide Attempt(s)	<input type="checkbox"/> Swelling Feet
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors, Growths
<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Unspec. Pleural Effusion	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other: _____	

Patient Name _____ Patient Signature _____ Date _____

Family Health History

Check all family members that apply

	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimotos)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Patient Name _____ Patient Signature _____ Date _____

Review of Symptoms

Indicated which of the below you have experienced in the **last 1-2 months.**

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Ears/Nose

Decreased Hearing 1 2 3 4 5
 Ear Drainage 1 2 3 4 5
 Ear Pain/Ear Infection 1 2 3 4 5
 Frequent Sneezing 1 2 3 4 5
 Headaches 1 2 3 4 5
 Hayfever 1 2 3 4 5
 Itchy/Watery Eyes 1 2 3 4 5
 Loss of Smell 1 2 3 4 5
 Nose Bleeds 1 2 3 4 5
 Nose Drainage/Runny 1 2 3 4 5
 Ringing in Ears 1 2 3 4 5
 Snoring 1 2 3 4 5
 Stuffy Nose 1 2 3 4 5
 TMJ 1 2 3 4 5

Eyes/Vision

Blindness 1 2 3 4 5
 Blurred/Double Vision 1 2 3 4 5
 Cataracts 1 2 3 4 5
 Eye Pain 1 2 3 4 5
 Field Cuts 1 2 3 4 5
 Glaucoma 1 2 3 4 5
 Itching 1 2 3 4 5
 Photophobia 1 2 3 4 5
 Tearing 1 2 3 4 5
 Wear Glasses/Contacts 1 2 3 4 5

Skin

Excessive Sweating 1 2 3 4 5
 Eczema 1 2 3 4 5
 Dryness 1 2 3 4 5
 Hives 1 2 3 4 5
 Itching 1 2 3 4 5
 Lumps 1 2 3 4 5
 Nail Texture/
 Skin Color Changes 1 2 3 4 5
 Rashes 1 2 3 4 5
 Skin Lesions 1 2 3 4 5
 Varicosities 1 2 3 4 5

Cardiovascular

Angina 1 2 3 4 5
 Chest Pain 1 2 3 4 5
 Claudication (leg pain/ache) 1 2 3 4 5
 Congestive Heart Failure 1 2 3 4 5
 Coronary Artery Disease 1 2 3 4 5
 Difficulty Breathing Lying 1 2 3 4 5
 Heart Murmur 1 2 3 4 5
 Heart Problems 1 2 3 4 5
 High Blood Press (no meds) 1 2 3 4 5
 High Blood Press (on meds) 1 2 3 4 5
 Low Blood Pressure 1 2 3 4 5
 Pacemaker/Defibrillator 1 2 3 4 5
 Palpitations 1 2 3 4 5
 Shortness of Breath
 with Exertion/Exercise 1 2 3 4 5
 Swelling of Legs 1 2 3 4 5
 Ulcers 1 2 3 4 5
 Varicose Veins 1 2 3 4 5
 Waking at Night -
 Shortness of Breath 1 2 3 4 5

Muscular/Skeletal

Ankle/Foot Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
 Arthritis 1 2 3 4 5
 Balance Problems
 Elbow Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
 Fibromyalgia 1 2 3 4 5
 Hip Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
 Joint Pain 1 2 3 4 5
 Knee Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
 Low Back Pain 1 2 3 4 5
 Muscle Aches 1 2 3 4 5
 Muscle Cramping
 Muscle Stiffness(in a.m.)
 Neck Pain 1 2 3 4 5
 Pain Between Shoulder 1 2 3 4 5
 Pain Wakens You 1 2 3 4 5
 Shoulder Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
 Weakness in Arms/Legs 1 2 3 4 5
 Wrist/Hand Pain 1 2 3 4 5
(Circle all that apply)
 Popping, Clicking, Weakness, Stiffness
Gastrointestinal
 Abdominal Pain/Cramps 1 2 3 4 5
 Abnormal Stool 1 2 3 4 5
 Belching 1 2 3 4 5
 Black/Tarry Stools 1 2 3 4 5
 Bloating/Gas 1 2 3 4 5
 Change in Appetite 1 2 3 4 5
 Change in Bowel Habit 1 2 3 4 5
 Constipation 1 2 3 4 5
 Crohn's Disease 1 2 3 4 5
 Diarrhea 1 2 3 4 5
 Hemorrhoids 1 2 3 4 5
 Indigestion 1 2 3 4 5
 Jaundice 1 2 3 4 5
 Rectal Bleeding 1 2 3 4 5
 Reflux/Heartburn 1 2 3 4 5
 Nausea/Vomiting 1 2 3 4 5
 Vomiting Blood 1 2 3 4 5
Throat/Respiratory
 Asthma/ Wheezing 1 2 3 4 5
 Bleeding Gums 1 2 3 4 5
 Chronic Cough 1 2 3 4 5
 Coughing up Blood 1 2 3 4 5
 Chest Congestion 1 2 3 4 5

Dentures 1 2 3 4 5
 Difficulty Swallowing 1 2 3 4 5
 Hoarseness 1 2 3 4 5
 Shortness of Breath 1 2 3 4 5
 Sore Throat 1 2 3 4 5

Hematologic

Anemia 1 2 3 4 5
 Ease of Bleeding 1 2 3 4 5
 Blood Clotting 1 2 3 4 5
 Blood Transfusion 1 2 3 4 5
 Bruise Easily 1 2 3 4 5
 Lymph Node Swelling 1 2 3 4 5

Neurological

Dizziness 1 2 3 4 5
 Facial/Limb Weakness 1 2 3 4 5
 Fainting/
 Loss of Consciousness 1 2 3 4 5
 Headaches 1 2 3 4 5
 Loss of Memory 1 2 3 4 5
 Migraines 1 2 3 4 5
 Numbness 1 2 3 4 5
 Seizures 1 2 3 4 5
 Sleep Disturbance 1 2 3 4 5
 Slurred Speech 1 2 3 4 5
 Stroke 1 2 3 4 5
 Tingling 1 2 3 4 5
 Tremor 1 2 3 4 5
 Unsteadiness of Gait 1 2 3 4 5

Mental/Emotional

Anxiety/Panic 1 2 3 4 5
 Behavioral Change 1 2 3 4 5
 Bi-Polar Disorder 1 2 3 4 5
 Blackouts/Amnesia 1 2 3 4 5
 Clumsy 1 2 3 4 5
 Confusion 1 2 3 4 5
 Cry Often 1 2 3 4 5
 Daytime Sleepiness 1 2 3 4 5
 Convulsions 1 2 3 4 5
 Depression 1 2 3 4 5
 Emotional Numbness 1 2 3 4 5
 Foggy Thinking 1 2 3 4 5
 Forgetfulness 1 2 3 4 5
 Have Considered Suicide 1 2 3 4 5
 Have Hallucinations 1 2 3 4 5
 Have Overused Alcohol 1 2 3 4 5
 Hyperactive 1 2 3 4 5
 Insecure 1 2 3 4 5
 Insomnia 1 2 3 4 5
 Jittery 1 2 3 4 5
 Memory Loss 1 2 3 4 5
 Mood Swings/Irritability 1 2 3 4 5
 Nervous Breakdown 1 2 3 4 5
 Grumpiness 1 2 3 4 5
 Poor Concentration 1 2 3 4 5
 Restless Leg Syndrome 1 2 3 4 5
 Shy 1 2 3 4 5
 Uses Tranquilizers 1 2 3 4 5
 Withdrawn 1 2 3 4 5
 Workaholic 1 2 3 4 5

Urinary

Blood in Urine 1 2 3 4 5
 Burning or Pain 1 2 3 4 5
 Frequency 1 2 3 4 5
 Incontinence 1 2 3 4 5
 Kidney Stones 1 2 3 4 5
 Urgency 1 2 3 4 5

Endocrine

Abnormal Urination 1 2 3 4 5
 Change in Appetite 1 2 3 4 5
 Decreased Endurance 1 2 3 4 5
 Diabetes 1 2 3 4 5
 Excessive Hunger 1 2 3 4 5
 Excessive Thirst 1 2 3 4 5
 Fatigue/Drowsiness 1 2 3 4 5
 Feel "Burned Out" 1 2 3 4 5
 Goiter 1 2 3 4 5
 Hair Loss/Hair Growth 1 2 3 4 5
 Hot Flashes/Night Sweats 1 2 3 4 5
 Hypo/Hyper Thyroid 1 2 3 4 5
 Inability to Lose Weight 1 2 3 4 5
 Poor Sleep 1 2 3 4 5
 Voice Changes 1 2 3 4 5
 Weight Loss/Gain 1 2 3 4 5

Reproductive

Burning Urination 1 2 3 4 5
 Cramps 1 2 3 4 5
 Frequent Urination 1 2 3 4 5
 Hormone Therapy 1 2 3 4 5
 Itching/Rash 1 2 3 4 5
 Decreased Libido 1 2 3 4 5
 Mood Swings 1 2 3 4 5
 STI's 1 2 3 4 5
 Infertility

Males Only:

Have you had a PSA? Yes No
Levels? 0-2 2-4 4-10 >10
 Erectile Dysfunction 1 2 3 4 5
 Genital Pain 1 2 3 4 5
 Hernia 1 2 3 4 5
 Impotence 1 2 3 4 5
 Urination at Night 1 2 3 4 5
 Prostate Enlargement 1 2 3 4 5
 Prostate Infection 1 2 3 4 5

Females Only:

Heavy Bleeding 1 2 3 4 5
 Hot Flashes 1 2 3 4 5
 Irregular Menstruation 1 2 3 4 5
 Ovarian Cysts 1 2 3 4 5
 Pain During Sex 1 2 3 4 5
 Painful Periods 1 2 3 4 5
 Vaginal Discharge 1 2 3 4 5
 Vaginal Dryness 1 2 3 4 5

Notes:

Patient Name _____ Patient Signature _____ Date _____

ADVANCED MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of spinal manipulation and manual therapy techniques and other physical rehabilitation procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the health care staff of Advanced Medical/Living Wellness and/or other licensed doctors of chiropractic who now or in the future work in this facility.

I have had an opportunity to discuss with a registered or licensed health care provider, the nature and purpose of diagnostic or treatment procedures. I understand that results are not guaranteed.

I understand and am informed that, in the practice of medicine and in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN

APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay LIVING WELLNESS/ADVANCED MEDICAL as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that HAVE BEEN OR WILL BE rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Patient Name _____ Patient Signature _____ Date _____