CONFIDENTIAL NEW PATIENT INFORMATION

Name_____ Date _____
Home Ph._____ Cell Ph._____
Address _____City _____ Zip _____ S.S.#_____
Age _____ Birth Date_____ Marital Status M S W D How many children? _____
Occupation_____ Employer_____ Office Ph. _____
Work Address_____ Email Address_____
Name of Spouse _____ Occupation _____ Employer_____
Who may we thank for referring you? _____

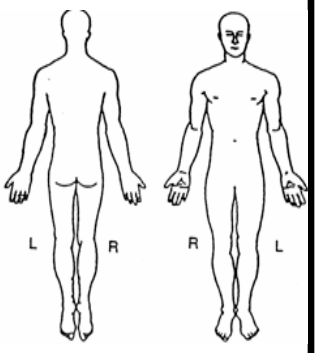
Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.:
1._____Date: _____
2. _____ Date: _____
3. _____ Date: _____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____
When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes
From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describe the pain:
☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____
What makes it better: _____ Worse:_____
Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing
☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping
Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
If yes, to either question above, please explain: _____
What other treatment have you had for this condition: _____
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

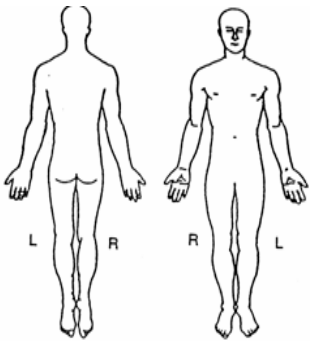
++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



SECONDARY CONDITION (If Applicable)
Please describe your secondary complaint: _____
When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes
From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describe the pain:
☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____
What makes it better: _____ Worse:_____
Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing
☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping
Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
If yes, to either question above, please explain: _____
What other treatment have you had for this condition: _____
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



ADDITIONAL CONDITION (If applicable)

Please describe any additional complaint: _____

When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

If yes, to either question above, please explain: _____

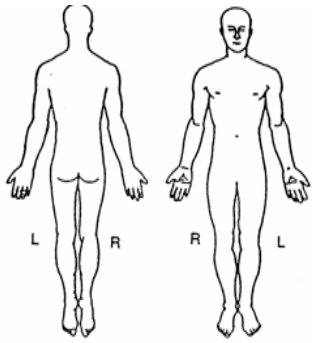
What other treatment have you had for this condition: _____

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning

XX Tingling/Numb 00 Dull



Medication/Supplements: Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Previous Hospitalizations / Surgeries / Serious illnesses

When? What? Hospital, City, State

_____

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Do you have Allergies to medications? NO YES What are your allergies? _____

Are you on Blood Thinners? NO YES

Patient Social History: (Place and X in your answer below)

Marital Status: (Circle one) Single Married Separated Divorced Widowed Domestic Partner

Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs: Never: _____ Type/Frequency: _____

Excessive Exposure: (Home or at Work) Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: ____ Noise: _____

Past Medical History (Have you ever had the following: (circle "yes" or "no" leave blank if you are uncertain.)

Anemia……	NO	YES	Diabetes……	NO	YES	Measles……NO		YES
Arthritis……	….NO	YES	Epilepsy……	NO	YES	Mitral Valve Prolapse…….NO		YES
AIDS & HIV……	NO	YES	Hives or Eczema……NO		YES	Mumps……	NO	YES
Asthma……	NO	YES	Glaucoma……NO		YES	Pneumonia……	NO	YES
Back Trouble……NO		YES	Mononucleosis ……	.NO	YES	Polio……	NO	YES
Bladder infection……	NO	YES	Hepatitis……	NO	YES	Rheumatic Fever……	.NO	YES
Bleeding Tendency…….	...NO	YES	Hernia……..NO		YES	Stroke……..NO		YES
Blood Transfusion…..NO		YES	High Blood Pressure……NO		YES	Thyroid Disease……	NO	YES
Bronchitis…… ……	NO	YES	Kidney Disease…..NO		YES	Tuberculosis…… …NO		YES
Cancer……	NO	YES	Low Blood pressure…...	NO	YES	Ulcer……NO		YES
Chicken Pox……..NO		YES	Migraine Headaches….	NO	YES	Whooping Cough……	NO	YES

Symptoms: check symptoms you have or have had in the past 6 months. Leave blank if not.

Constitutional	Respiratory	Cardiovascular
____ Chills ____ Fever ____ Feeling poorly ____ Feeling tired ____ Weight gain ____ Weight loss	____ Cough ____ Wheezing ____ Shortness of breath ____ Trouble breathing w/exercise ____ Trouble breathing w/lying flat ____ Snoring	____ Chest pain ____ Palpitations ____ Fast pulse ____ Slow pulse ____ Leg pain w/exercise ____ Leg swelling
Gastrointestinal	**Musculoskeletal**	**Neurological**
____ Abdominal pain ____ Nausea/Vomiting ____ Constipation ____ Diarrhea ____ Heartburn ____ Blood in stool _____Stool incontinence	____ Pains in joints ____ Neck pain ____ Back pain ____ Joint swelling ____ Joint stiffness ____ Muscle aches ____ Limb swelling	____ Numbness ____ Weakness ____ Dizziness ____ Fainting ____ Confusion ____ Headache

Primary Physician: I authorize this office to communicate to my primary physician about the care I receive.

Primary physician: _____ Address: _____ City: _____

Physician Phone #: _____ Pt. Signature: _____Date:_____

Female Only:

Are you currently having menstrual cycles? __Yes __ No

if yes, when was the first day of your last cycle? _____

Is there any chance you are pregnant? _____ Yes _____ No

If no, please sign here: _____

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
Postcards mailed to the addresses I have provided. Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

____ 7. I give Premier Wellness Group permission to treat me in an room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Medical Staff at any time in private, I understand the staff will provide a private room for consultations

____ 8. The Medical Staff recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

____ 9. I grant Premier Wellness Group, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Premier Wellness Group, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Premier Wellness Group may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and posture analysis.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date:_____ Name (Printed) _____ Name (Signed)_____

TERMS OF ACCEPTANCE

When a patient seeks medical, chiropractic or rehabilitation care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Medical Treatment I understand that the practice of medicine is not an exact science and that NO GURANTEES OR ASSURANCES have been made to me concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary to perform other procedures which are unforeseen, or not known to be needed at the time of this signed consent/authorize the physician herein to make the decision concerning such procedure, if additional procedures are deemed necessary or appropriate.

I also consent to the diagnostic studies, test, local anesthesia and/or general anesthesia, x-ray examinations and any other course of treatment related to the diagnosis or procedure explained herein. Too, I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.

Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions.

However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it.

The nature of the spinal decompression: You will be harnessed in with 2 separate harnesses and your spine will be gently lengthened in order to decompress herniated or bulging discs or re-hydrate degenerated discs.

The material risks inherent with spinal decompression: As with any healthcare procedure, there are certain complications that may arise during spinal decompression. This may include: strains, muscle spasms, disc injuries and worsening of your pain. This list is not all inclusive.

The probability of those risks: The complications listed are considered rare. The most common risk is a dull, achy soreness similar to having just worked out for the first time in a long time. This is usually due to stretching of tight muscles that haven't been stretched in this way. This will typically go away within the first week or two of treatments. We will warm the tissues up before treatment and will decompress your spine more conservative at first to prevent as much soreness as we can. It is recommended that you ice for 20 minutes up to 3 times daily for the first week to decrease pain and soreness.

Ancillary treatments and or Physical Therapy recommended: Ice, Moist Heat Packs, Cold Laser Therapy Stretching/Strengthening Exercises, Massage Therapy, Electrical muscle stimulation.

Risks involved with the recommended ancillary treatments:
Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Decompression Spinal Traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure or the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of spinal decompression and the related treatment. I have discussed it with the doctor 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 I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I understand that there are no guarantees as to the success of my individual treatment and that individual treatment may vary from patient to patient. I also understand that the payment for the treatment is prorated.

Date:_____ Name (Printed)_____Name (Signed)_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

To: Premier Wellness Group

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.

3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Date:_____ Name (Printed) _____ Name (Signed)_____

DISCLOSURE OF OWNERSHIP INTEREST

The physicians of the Premier Wellness Group are required by federal law to disclose any ownership or financial interest in any healthcare facilities where our patients may receive care. Premier Wellness Group is D.C. physician owned. Premier Wellness Group may advise you at some point during the course of your treatment, you may be referred out of the clinic for such conditions that cannot be treated or diagnosed in the clinic. Such conditions but not limited to that may require a referral are: (Orthopedic, Neurologic, and Diagnostic). Premier Wellness Group has no ownership or finical interest in such referral.

We will provide you with names and addresses of other providers that are near to your home or place of work. If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office. We welcome you as a patient and value our relationship with you.

Date:_____ Name (Printed) _____ Name (Signed)_____