

# R2 WELLNESS CENTERS

2072-B East Commercial Ave Lowell, IN 46356 | Phone: 219-696-8916 | Fax: 219-696-6880 | info@r2wellnesscenters.com

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**WELCOME TO R2 WELLNESS CENTERS!**

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To begin, how did you hear about our office? \_\_\_\_\_

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## PATIENT INFORMATION:

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

SS#/SIN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email address: \_\_\_\_\_

Home phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated

Patients address - Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Spouse/Parent/Guardian's name: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Emergency contact relationship to patient:  Spouse  Parent/Guardian  Other: \_\_\_\_\_

*\*In case of medical emergency, if the patient is of school age 15+, it is okay to treat in my absence.*

Parent or guardian signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## RESPONSIBLE PARTY:

Check if the patient is the responsible party (If so, you are not required to fill out this section)

Name of responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Party's address - Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Is the responsible party currently a patient?  Yes  No

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## INSURANCE HOLDER:

Do you have insurance?  YES  NO (If NO, then you are not required to fill out this section)

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#/SIN: \_\_\_\_-\_\_\_\_-\_\_\_\_ INS ID number: \_\_\_\_\_

Employer: \_\_\_\_\_ Union Number: \_\_\_\_\_ Insurance company: \_\_\_\_\_

Employer address - Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Insurance address - Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

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## HEALTH HISTORY:

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Chief complaint: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS:

Location: \_\_\_\_\_ Quality: \_\_\_\_\_ Severity: \_\_\_\_\_  
(Where is the pain/problem located?) (Example: Normal vs abnormal color, activity, ect) (Pain on scale 1-10, 10 being most severe)

Duration: \_\_\_\_\_ Timing: \_\_\_\_\_ Context: \_\_\_\_\_  
(How long have you had this pain, when did it begin?) (Does the pain/problem occur at a certain time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: \_\_\_\_\_  
(What other associated problems have you been having?)

Modifying factors: \_\_\_\_\_  
(What makes the pain/problem worse or better? Have you had previous episodes?)

## PAST MEDICAL HISTORY:

Have you ever had the following (CIRCLE "YES" or "NO" or leave blank if you are uncertain)

Measles:	YES NO	Anemia:	YES NO	Back trouble:	YES NO
Mumps:	YES NO	Bladder infection:	YES NO	High Blood Pressure:	YES NO
Chicken Pox:	YES NO	Epilepsy:	YES NO	Low Blood Pressure:	YES NO
Whooping cough:	YES NO	Migraines:	YES NO	Hemorrhoids:	YES NO
Scarlet fever:	YES NO	Tuberculosis:	YES NO	Asthma:	YES NO
Diphtheria:	YES NO	Diabetes:	YES NO	Hives of Eczema:	YES NO
Small pox:	YES NO	Cancer:	YES NO	AIDS and HIV:	YES NO
Pneumonia:	YES NO	Polio:	YES NO	Infectious MONO:	YES NO
Rheumatic fever:	YES NO	Glaucoma:	YES NO	Bronchitis:	YES NO
Arthritis:	YES NO	Hernia:	YES NO	Mitral Valve Prolapses:	YES NO
Venereal Disease:	YES NO	Blood Transfusion:	YES NO	Stroke:	YES NO
Hepatitis:	YES NO	Plasma Transfusion:	YES NO	Date of last chest x-ray:	_____
Ulcer:	YES NO	Kidney Disease:	YES NO	Thyroid Disease:	YES NO
Bleeding Tendency:	YES NO	Any other diseases:	YES NO		_____

## Previous Hospitalizations/Surgeries/Serious Illnesses:

\_\_\_\_\_ When: \_\_\_\_\_ Hospital/City/State: \_\_\_\_\_

\_\_\_\_\_ When: \_\_\_\_\_ Hospital/City/State: \_\_\_\_\_

## MEDICATIONS:

(LIST and be sure to include NON-Prescription)

Have you ever taken Fen-Phen/Redux? YES NO Are you taking any medications for acid indigestion? YES NO  
(Include prescription/over the counter) If YES, what type?: \_\_\_\_\_

## ALLERGIES:

(List ALL allergies/sensitivities to medications, food, and other items)

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

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## PATIENT SOCIAL HISTORY:

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## FAMILY MEDICAL HISTORY:

Disease (if applicable)	Relation
_____	_____
_____	_____
_____	_____

## INDICATE WHICH OF THE BELOW YOU HAVE EXPERIENCED WITHIN THE LAST 1-2 MONTHS

On a scale of 1-5, below indicate how often you deal experience the associated issue. 1 – Being Never 5 – Being Always

EYES/EARS/NOSE THROAT/RESPIRATORY	MUSCULAR & SKELETAL	NEUROLOGICAL	GENERAL
Asthma 1 2 3 4 5	Muscle Aches 1 2 3 4 5	Headaches 1 2 3 4 5	Fatigue 1 2 3 4 5
Stuffy nose 1 2 3 4 5	Fibromyalgia 1 2 3 4 5	Migraines 1 2 3 4 5	Malaise 1 2 3 4 5
Hay Fever 1 2 3 4 5	Arthritis 1 2 3 4 5	Dizziness 1 2 3 4 5	Weakness 1 2 3 4 5
Sore throat 1 2 3 4 5	Joint pain 1 2 3 4 5	Numbness 1 2 3 4 5	Tiredness 1 2 3 4 5
Chronic cough 1 2 3 4 5	Low back pain 1 2 3 4 5	Tingling 1 2 3 4 5	Lightheadedness 1 2 3 4 5
Chest congestion 1 2 3 4 5	Neck pain 1 2 3 4 5	Pins/Needles 1 2 3 4 5	Irritability 1 2 3 4 5
Frequent sneezing 1 2 3 4 5	Wrist/Hand pain 1 2 3 4 5		Constipation 1 2 3 4 5
Itchy/watery eyes 1 2 3 4 5	Elbow pain 1 2 3 4 5		Diarrhea 1 2 3 4 5
Drainage 1 2 3 4 5	Shoulder pain 1 2 3 4 5		Feeling groggy 1 2 3 4 5
Earache/infection 1 2 3 4 5	Hip pain 1 2 3 4 5		Forgetfulness 1 2 3 4 5
Itching 1 2 3 4 5	Knee pain 1 2 3 4 5		
Hoarseness 1 2 3 4 5	Ankle pain 1 2 3 4 5		
Short of breath 1 2 3 4 5	Foot pain 1 2 3 4 5		
Wheezing 1 2 3 4 5	Pain between Shoulder blades 1 2 3 4 5		

To the best of knowledge, the questions on this form have all been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

\_\_\_\_\_  
Signature of the Patient, Parent, or Guardian

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of the Doctor

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### Notice to Patient:

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and or disclose your health information. A copy of our current Notice of Privacy Practices is available upon request to staff, as well as on our website. You are entitled to a copy of our Notice of Privacy Practices. Please sign this form to acknowledge that the Notice of Privacy Practices was made available to you. You may refuse to sign this acknowledgement if you wish.

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I \_\_\_\_\_ am aware that the Notice of Privacy Practices is in effect as of  
(Print Patient, Parent, Guardian name) March 20, 2006. I acknowledge that this copy of R2 Wellness Centers  
Notice of Privacy Practices was made available to me.

\_\_\_\_\_  
Please print the Patients name

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of the Patient, Parent, or Guardian

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

\_\_\_\_\_ The patient refused to sign

\_\_\_\_\_ Other

\_\_\_\_\_  
Employee signature

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## CONSENT TO TREAT

I hereby authorize and consent to the performance of chiropractic manipulation and/or manual therapy techniques as well as other chiropractic procedures. These may include various modes of physical therapeutic modalities and procedures, as well as diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible). These services performed by the Doctor of Chiropractic and/or other licensed doctors who now or in the future work at R2 Wellness Centers. I have had or understand that I will have an opportunity to discuss with the Doctor the nature and purpose of chiropractic adjustments and other procedures, prior to treatment. I understand that results are not guaranteed.

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

- Manipulation (Chiropractic adjustments): Increased pain/discomfort, fractures, disc injuries, strokes, dislocations/sprains
- Therapeutic Modalities and Procedures (Rehabilitation): Additional pain/discomfort. Endurance exercises 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 become pregnant

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

The above medical information is true and accurate to the best of my knowledge. I am aware of and will inform my practitioner(s) of any changes in my health. My records are confidential except in special situations including in the case of abuse, neglect or harm to others and noted in the Notice of Privacy Practices provided to me. I take full responsibility for alerting my chiropractic doctor to any physical condition that would affect this therapy. I do not have any injuries or conditions that would prevent me from receiving a chiropractic adjustment, nor have I been told by a healthcare provider that I should not receive such treatment. I understand that it is my responsibility to communicate with my chiropractor any concerns or questions about therapy. I have had the opportunity to ask questions regarding these risks and any possible complications. I further certify that my chiropractor has informed me of the nature and character of the proposed treatment, anticipated results of this procedure, possible alternative treatment choices, as well as possible risks or complications involved in the proposed treatment. I understand that this chiropractic treatment, while intended to manage certain conditions, has no guarantee of success or effectiveness.

I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results or complications and hereby waive liability if such results or complications occur.

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I \_\_\_\_\_ have read, or have had read to me, the above consent. I have also had an  
(Print Patient, Parent, Guardian name) opportunity to ask questions about it's content. 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 is seek treatment.

\_\_\_\_\_  
Signature of the Patient, Parent, or Guardian

Todays date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of the Doctor

Todays date: \_\_\_\_/\_\_\_\_/\_\_\_\_