Name: _____Date _____ Provider Signature: _____

Apple Wellness Center

609 Cedar Creek Grade, Suite B, Winchester VA 22601
Phone: 540-545-7891 Fax: 540-545-7893

Patient Information

Full Name: _____ Social Security Number: _____
Date of Birth: _____ Age: _____ Sex (circle one): Male Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Employer: _____ Work Phone: _____
Status (circle one): Married Single Partnered Divorced Widowed Separated Minor
Primary Care Provider: _____ City, State: _____
Are you currently under a doctor's care? Yes/No For what? _____
Name of Doctor: _____ City, State: _____
How did you hear about us? _____
What prompted you to choose us for your healthcare needs? _____

Emergency Contact

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

Insurance Information

Primary Subscriber: _____ Relation to Patient: _____
Insurance Company: _____ ID Number: _____
Secondary Insurance: _____ ID Number: _____

Assignment and Release

I understand and agree that, regardless of the insurance or medical benefits I have, I am ultimately responsible to pay Apple Wellness Center the balance due on my account for any professional services rendered and for any supplies, or tests provided. I hereby authorize payment of any health insurance or medical plan benefits directly to Apple Wellness Center for medical services rendered and for any supplies, or tests provided. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in my 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 other legal remedies necessary in connection with the same. I hereby assign directly to Apple Wellness Center all current and prior rights, if any, to payment and benefit and all legal and other health plan rights that I have or my child, spouse, or dependent may have under my/our applicable health plan(s) or health insurance policy. This assignment includes, but is not limited to, a designation that Apple Wellness Center personnel can act on my/ our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Apple Wellness Center as a result of services rendered by Apple Wellness Center and authority to pursue any and all remedies to which I/we may be entitled to, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing and a photocopy is to be considered as valid and enforceable as the original.

Financial Policy

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time of service rendered, unless prior arrangements have been made. For your convenience, we accept all major credit card, cash, and checks. I agree that should this account be referred to an agency or attorney for collection, I will be responsible for all collection costs, attorney, and court fees and costs.

I have read and understand all of the above statements and have agreed to these statements.

Print Name: _____ Signature: _____ Date: _____

Guardian Name: _____ Signature: _____ Date: _____

Name: _____Date _____ Provider Signature: _____

Medical History

Gynecologic History (Females Only)
Are you currently pregnant? Yes/No Pregnancies #: _____ Deliveries #: _____
Natural or C-Section? _____ Dates: _____
Menstrual - Onset: _____ Duration: _____ Last Cycle: _____
Are they regular? Yes/No Are they painful? Yes/No

General History (Check all that apply to you):

__AIDS/HIV	__Alcoholism	__Allergy Shots	__Anemia
__Appendicitis	__Arthritis	__Asthma	__Anorexia
__Blood Disorders	__Blood Transfusion	__Breast Lump	__Bronchitis
__Bulimia	__Caner	__Cataracts	__Chemical Dependency
__Chest Pain	__Chicken Pox	__Cholera	__Constipation
__Diabetes	__Eating Disorders	__Emphysema	__Epilepsy
__Fractures	__Gallbladder	__Glaucoma	__Goiter
__Gonorrhea	__Gout	__Heart Attack	__Heart Disease
__Hepatitis	__Hernia	__Herniated Disc	__Herpes
__High Blood Pressure	__High Cholesterol	__Hormone Replace	__Hypertension
__Jaundice	__Kidney Disease	__Liver Disease	__Malaria
__Measles	__Migraines	__Miscarriage	__Mononucleosis
__Multiple Sclerosis	__Mumps	__Nervous Habits	__Osteoporosis
__Pacemaker	__Parkinson's	__Pinched Nerve	__Pleurisy
__Pneumonia	__Polio	__Prostate Problems	__Prosthesis
__Psychiatric Care	__Rheumatoid Arth.	__Rheumatic Fever	__Scarlet Fever
__STD	__Stroke	__Suicide Attempt	__Swelling Feet
__Thyroid Problems	__Tonsillitis	__Tuberculosis	__Tumors/Growths
__Typhoid Fever	__Ulcers	__Vaginal Infection	__Whooping Cough
__ Vertigo	__ Other: _____	__ Other: _____	__ Other: _____

Medications (Please list all medications taken regularly and the dosage of each, Including Birth Control):_____
_____

Medical and General Allergies: _____
_____

Surgical History (Please list all past surgeries with dates and any surgical devices, if any): _____
_____

Family History (Please list any significant or hereditary conditions):_____
_____

Social Habits (check all that apply):
__Alcohol Drinks per week: _____
__Smoking Packs per day: _____
__Coffee/Caffeine Cups per day: _____
__High Stress Reason: _____

Activity Level:
__Inactive (No regular physical activity, including work)
__Lightly Active (No organized physical activity during leisure time)
__Moderately Active (Occasionally involved in actives such as golf, tennis, jog, swim, cycle)
__Heavily Active (Consistent lifting, stair climbing, regular sports at least 3 times per week)
__Vigorously Active (Extensive activity for 60 minutes, 4 times per week or more)

Name: _____Date _____ Provider Signature: _____

Current Nutrition:
Height: _____ Weight: _____ Ideal Weight: _____
Do you snack after meals? Yes/No If yes, what and how much do you eat? _____
_____
What beverages do you drink throughout the day? _____

History of Present Illness

Headache/Migraine?	Yes/No	How Often: _____
Neck Pain?	Yes/No	How Often: _____
Shoulder Pain? L/R	Yes/No	How Often: _____
Elbow Pain? L/R	Yes/No	How Often: _____
Mid-Back Pain?	Yes/No	How Often: _____
Lower Back Pain?	Yes/No	How Often: _____
Hip Pain? L/R	Yes/No	How Often: _____
Knee Pain? L/R	Yes/No	How Often: _____
Ankle Pain? L/R	Yes/No	How Often: _____

Main Complaint:

1. When did the symptoms start? _____
2. How did they begin? _____
3. Have you had it before? Yes / No If yes, describe: _____
   _____
4. Exactly how does the symptom feel? _____
   _____
5. Rate the severity from 1 – 10 (1=Mild, 10=Severe): _____
6. Timing of symptoms:
   How many times a day: _____ How long it lasts: _____
   How many times a week: _____ How long it lasts: _____
   How many times a month: _____ How long it lasts: _____
7. Does it radiate? Yes / No If yes, from where to where? _____
   _____
8. What makes the symptom feel better or relieves it? _____
   _____
9. What makes it feel worse or aggravates it? _____
   _____
10. Is there a family history of this? Yes / No If yes, Who? _____
    _____
11. Are you taking prescription medications for this? Yes / No If yes, What? _____
    _____
12. Have you had previous treatment for this? Yes / No If yes, Who did you see and what was the outcome? _____

Name: _____Date _____ Provider Signature: _____

13. What have you tried on your own and what were the results? (Examples: Heat or Ice, OTC Meds, Stretching, Chiropractic, Physical Therapy etc.) _____

_____

Additional Complaint:

1. When did the symptoms start? _____
2. How did they begin? _____
3. Have you had it before? Yes / No If yes, describe: _____

   _____
4. Exactly how does the symptom feel? _____

   _____
5. Rate the severity from 1 – 10 (1=Mild, 10=Severe): _____
6. Timing of symptoms:

   How many times a day: _____ How long it lasts: _____

   How many times a week: _____ How long it lasts: _____

   How many times a month: _____ How long it lasts: _____
7. Does it radiate? Yes / No If yes, from where to where? _____

   _____
8. What makes the symptom feel better or relieves it? _____

   _____
9. What makes it feel worse or aggravates it? _____

   _____
10. Is there a family history of this? Yes / No If yes, Who? _____

    _____
11. Are you taking prescription medications for this? Yes / No If yes, What? _____

    _____
12. Have you had previous treatment for this? Yes / No If yes, Who did you see and what was the outcome? _____
13. What have you tried on your own and what were the results? (Examples: Heat or Ice, OTC Meds, Stretching, Chiropractic, Physical Therapy etc.) _____

    _____

*Please request additional form if you have additional complaints.

Name: _____Date _____ Provider Signature: _____

Patient Functional Limitation

List 3 specific activities that you are having the most trouble with. Our GOALS will be based upon what you write, so be as specific as possible.

Put the date of your first visit in the first date column. The additional date columns will be used throughout you treatment to re-evaluate your functional limitations.

In the column marked "Score", rate your level of difficulty – Limitation rates are based on a scale of 0 to 10 using the scale below as your guide.

0 1 2 3 4 5 6 7 8 9 10
No Limitation **Severe Limitation**

Date Tested:	/ /	/ /	/ /	/ /	/ /	/ /
Specific Activity:	Score:	Score:	Score:	Score:	Score:	Score:

Name: _____Date _____ Provider Signature: _____

Notice of HIPAA Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

A Notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of your health information is available to you upon request. We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations.

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. PAYMENT means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review. HEALTH CARE OPERATIONS include managing your Electronic Medical Record to facilitate diagnostic medical consultations with participating physicians, as well as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may contact you to provide information about our services or other health-related services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete. You have a right to receive a list of certain instances when we have used or disclosed your medical information. If you ask for this information from us more than once every twelve months, we may charge you a fee.

I have read and understand the above statement and agree to these privacy practices.

Patient Name: _____ Date: _____

Patient Signature: _____

Notice of Privacy

I hereby authorize Apple Wellness Center and or any of its doctors, chiropractors, and staff to share and update my medical information from this office with the following person(s), family member(s), etc.

Person or Family Member Authorized: _____

Patient Name: _____ Date: _____

Patient Signature: _____