WELCOME TO WOODBURY SPINE

Welcome to our office!

We are sure that you will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with today's examination procedures, which will determine how we can help you, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes: dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs that these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we get from you is important. We use your health history, x-rays, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time to the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Justin & Woodbury Spine Staff

WOODBURY SPINE
WELLNESS CENTER
A COMMUNITY INSPIRED BY WELLNESS

Adult Member Health Record

Patient Information

First Name: Last Name: Date:

Date of Birth: Age: Sex: ◯ Male ◯ Female Phone: - - cell/home

◯ Check if you want text reminders for apts.

Marital Status: # of children: Occupation:

Street Address: Height: ft in

City: State: Zip: Weight:

Email: Insurance Company:

Employers Name: Address: Phone: - -

Emergency Contact: Relation: Phone: - -

How did you hear about our office? If you were referred in, who referred you to our office?

Who is your primary care physician? Date and reason for last visit:

Are you receiving care from any other health care provider? ◯ Yes ◯ No What is their specialty?

Please note any significant medical history:

Current Health Conditions

What health condition(s) bring you to our office?

Have you ever received care for the condition before? ◯ Yes ◯ No If yes, please explain:

When did the condition(s) begin?

Is the purpose of this appointment related to: ◯ Chronic Discomfort ◯ Home Injury ◯ Sports ◯ Auto Injury ◯ Fall ◯ Work Injury ◯ Other:_____

If job related have you made a report of the accident to your employer? ◯ Yes ◯ No

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is the condition? ◯ Getting Worse ◯ Staying the same ◯ Improving ◯ Come and Gone ◯ Unsure

What makes the condition better? What makes the condition worse?

The condition(s) interferes with: ◯ Sleep ◯ Daily Routine ◯ Other Activities

Please Explain:

Last Name, First Name:

Chiropractic Experience

Have you ever been adjusted by a chiropractor? ○ Yes ○ No

If so, what was the reason for those visits?

Doctor of Chiropractics Name? Approximate Date of Last Visit:

What would you like to gain from chiropractic care? ○ Resolve Existing Condition(s) ○ Overall Wellness ○ Both

Do you have any health concerns for any other family members today?

Health Habits

Do you smoke? ○ Yes ○ No How often?

Do you drink alcohol? ○ Yes ○ No How many drinks per week?

Do you drink coffee, tea, or soda? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No

If so how many times per week? _____

If no, is that something you would like to improve? ○ Yes No ○

Trauma/Physical Injury History

Have you had any significant falls, injuries, or surgeries as an adult? ○ Yes ○ No If yes, explain:

Have you had any significant falls, injuries, or surgeries as a child? ○ Yes ○ No If yes, explain:

Youth or College Sports Injury? ○ Yes ○ No If yes, explain:

Any Auto Accidents? ○ Yes ○ No If yes, explain:

Any problems with flexibility? (exp. putting on socks/shoes/etc.)

How many hours a day do you typically spend sitting at a desk, computer, tablet, phone, etc?

Health Conditions

Please **CIRCLE** each of the conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.

Severe or frequent headaches	Thyroid Problems	Pain in arms/legs/hands	Numbness
Heart Surgery/Pace Maker	Sinus Problems	Low Blood Pressure	Allergies
Lower Back Problems	Hepatitis	Rheumatic fever	Diabetes
Digestive Problems	Difficulty breathing	Ulcers/colitis	Asthma
Pain Between Shoulders	Kidney problems	Tuberculosis	Loss of Sleep
Congenital Heart Defect	High blood pressue	Arthritis	Dizziness
Frequent Neck Pain	Chemotherapy	Shingles	Other_____

Last Name, First Name:

Medications

○ Cholesterol ○ Blood Pressure ○ Stimulants ○ Blood Thinners ○ Glucose ○ Pain Killers

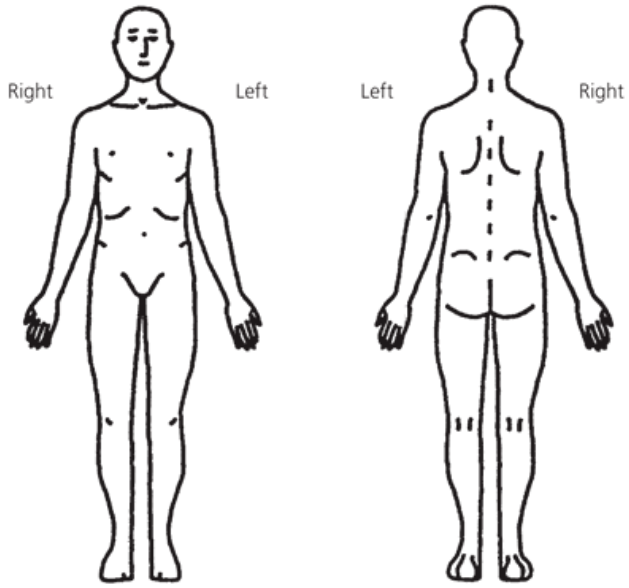
○ Aspirin/etc. ○ Muscle Relaxers ○ Insulin ○ Others:_____

Please list any vitamins or supplements that you take on a regular basis: _____

_____

Your Conditions

1) Please indicate where you are experience pain/discomfort:
X= Current. O= Past Conditions



2) Using the pain scale below, circle the level you experience when the problem/s is at its worst:

0=**No Pain**. No Discomfort
1=**Minimal Discomfort**. Minor stiffness or tightness.
2=**Mild Pain**. Noticeable pain but tolerable.
3=**Moderate**. Aggravating but still allows movement.
4=**Strong Pain**. Aggravating with minimal movement.
5=**Severe Pain**. Unbearable and no movement.

3) Please **Circle** the health concern(s) you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and fuction of the nerves.

	C1	Headaches, Migraines, Dizziness, Sinus Problems, Allergies, Fatigue, Head Colds, Vision Problems, Difficulty Concentrating, Hearing Problems
	C2	
	C3	
Sore Throat, Stiff Neck, Radiating Arm Pain, Hand/Finger Numbness, Asthma, Allergies, High Blood Pressure, Heart Conditions	C4	
	C5	
	C6	
	C7	
	T1	
	T2	Mid Back Pain, Congestion, Difficulty Breathing, Bronchitis, Pneumonia, Gallbladder Conditions, Stomach Problems/Ulcers, Gastritis, Kidney Conditions
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
Constipation, Colitis, Diarrhea, Gas Pain, Irritable Bowel, Bladder Conditions, Menstrual Conditions, Low Back Pain, Pain or Numbness in Low Back, Reproductive Conditions	L1	
	L2	
	L3	
	L4	
	L5	
	S	
	A	
	C	
	R	
	A	
	L	

Health Goals

Check any of your health goals:

○ Improve Nutrition/Eating Habits ○ Increase Lean Muscle Mass ○ Start Exercising ○ Improve Energy

○ Weight Loss/Fat Loss ○ Reduce Stress ○ Improve Sleep ○ Reduce Pain

○ Improving Movement/flexibility ○ Lower Cholesterol/Blood Pressue ○ Improve Posture ○ Other:_____

Last Name, First Name:

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice of care will be made only after obtaining your consent:

1. You may request restrictions on your disclosures.
2. You may inspect and receive copies of your records within 30 days of a request.
3. You may request to view changes to your records
4. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
2. *Obtain payment from third party payers.*
3. *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that I can restrict how my personal information is used or disclosed.

Patient's Name (please print): Relation to Patient (self/parent/guardian):

Signature: Date:

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: Date:

Witness' Signature: Date:

Last Name, First Name:

Payment Agreement/Use of Insurance Authorization

I hereby authorize the Doctors of Woodbury Spine Wellness Center to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Woodbury Spine Wellness Center will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Woodbury Spine Wellness Center, LLC for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Woodbury Spine Wellness Center will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Woodbury Spine Wellness Center, LLC will be credited to my account upon receipt.

Signature: Date:

Guardian/Authorized Person of Care Signature: Date:

Who should receive bills for payment on your account?

○ Patient ○ Spouse ○ Parent ○ Workers Comp ○ Auto Insurance ○ Medicare ○ Health Insurance

Date of Birth:

Insurance Company: ID# Group ID:

Authorization For Care Of a Minor

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate such as mobility, massage, and any therapy the doctor seems appropriate as discussed with parent. I clearly understand and agree that all services rendered by my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. Nye & the Doctors of Woodbury Spine will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Woodbury Spine Wellness Center, LLC directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

Name of Child:

Parent or Guardian Authorizing Care's Name (please print): Birthdate:

Signature of Parent or Guardian: Date:

X-ray Consent

I hereby give my consent to Woodbury Spine Wellness Center and it's representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature: Date:

Last Name, First Name:

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

Address:

Phone:

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

1. A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
2. B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
    1. Mental health records
    2. Communicable diseases (including HIV and AIDS)
    3. Alcohol/drug abuse treatment
    4. Other (please specify):
    5. _____
    6. _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

1. An electronic record or access through an online portal
2. Hard copy

This authorization shall be effective until (Check one):

1. All past, present, and future periods, OR
2. Date or event:_____
   unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of Individual Giving this Authorization (please print): Date of Birth:

Signature of Individual Giving this Authorization: Date:

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

MEDICAL SYMPTOM QUESTIONNAIRE

Name:_____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past **30 days.**

Point Scale

0 - Never or almost never have the symptom

1 - Occasionally have it, effect is not severe

2 - Occasionally have it, effect is severe

3 - Frequently have it, effect is not severe

4 - Frequently have it, effect is severe

Head _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia **Total** _____	**Energy/ Activity** _____ Fatigue, Sluggishness _____ Apathy, Lethargy _____ Hyperactivity _____ Restlessness **Total** _____	**Lungs** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing **Total** _____
Eyes _____ Watery or Itchy Eyes _____ Swollen, Reddened or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (does not include near or far-sighted) **Total** _____	**Weight** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight **Total** _____	**Heart** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain **Total** _____
Ears _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss **Total** _____	**Emotions** _____ Mood Swings _____ Anxiety, Fear, Nervousness _____ Anger, Irritability, Aggressiveness _____ Depression **Total** _____	**Digestion** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain **Total** _____
Nose _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation **Total** _____	**Mind** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty in Making Decisions _____ Stuttering or Stammering _____ Slurred Speech _____ Learning Disabilities **Total** _____	**Skin** _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating **Total** _____
Mouth/Throat _____ Chronic Coughing _____ Gagging, Frequent Need to Clear Throat _____ Sore Throat, Hoarseness, Loss of Voice _____ Swollen or Discolored Tongue, Gums, or Lips _____ Canker Sores **Total** _____	**Joints/Muscles** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limitation of Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness **Total** _____	**Other** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge **Total** _____ **Grand Total** _____

Woodbury Spine Wellness Center

What are you interested in learning more about today? Check the box that applies:

☐ **8 WEEKS TO WELLNESS**

- As a wellness patient I want the ultimate opportunity to be well.
- My goals are to have a healthy nervous system that is free of interference and pain.
- I want to lose weight and gain energy by doing in-office workouts and massages.
- I want to know how to stay chemically healthy by learning how to eat right and still enjoy my lifestyle.
- I want to change my life and have the life I have always wanted.
- I want to EAT better, MOVE better and THINK better. I want 8 Weeks to Wellness!

☐ **CHIROPRACTIC CARE (SLIGHT INTEREST IN WELLNESS)**

- As a patient my first concern is to address the health of my nervous system through chiropractic.
- Once my nervous system is healthier, my next desire is to look at ways to achieve the ultimate healthy lifestyle through 8 weeks to wellness and its components

☐ **STANDARD**

- As a Chiropractic Patient I will experience life through a new healthy nervous system.
- My goals are to go through three phases of care to a healthier nervous system by eliminating my body's malfunction, correcting the subluxations that exist in my spine, and maintaining them through full spectrum chiropractic & mobility sessions.