THE VILLAGE WELLNESS CENTER

HEALTH HISTORY

Name:_____ **Chart #:**_____ **Date:**_____

Please circle all that apply: **Patients family (do not include relations by marriage)**

Condition	Patient	Family		Condition	Patient	Family
Abdominal Pain	P	F		MS	P	F
ADD/ADHD	P	F		Osteoporosis	P	F
Allergies	P	F		PMS	P	F
Anemia	P	F		Poor Memory	P	F
Aortic Aneurysm	P	F		Profuse Menses	P	F
Arthritis	P	F		Prostate Disease	P	F
Asthma	P	F		Rheumatic Fever	P	F
Blood Disorder	P	F		Scoliosis	P	F
Cancer	P	F		Sex Transmitted Diseases	P	F
Chronic Fatigue Syndrome	P	F		Sickle Cell Anemia	P	F
Crohn's, Colitis, Irritable Bowl	P	F		Sinus Trouble	P	F
Constipation	P	F		Spinal Disc Disorder	P	F
Depression	P	F		Stroke	P	F
Diabetes	P	F		Thyroid Disorder	P	F
Dizziness	P	F		Trouble Concentrating	P	F
Eating Disorder	P	F		Trouble Sleeping, Insomnia	P	F
Emphysema	P	F		Tuberculosis	P	F
Excess Sweating, Night Sweats	P	F		Weight Gain/Loss	P	F
Epilepsy	P	F		Under Stress, Irritable	P	F
Fainting	P	F		Ulcer	P	F
Fibromyalgia	P	F		Others:	P	F
Frequent Colds, Flu	P	F			P	F
Headaches, Migraines, Tension	P	F			P	F
Heart Attacks, Heart Disease	P	F			P	F
Heart Burn, Indigestion, Gas	P	F			P	F
High, Low Blood Pressure	P	F			P	F
Kidney Disease	P	F			P	F
Lung Disease	P	F			P	F
Mood Changes	P	F			P	F

Patient Exercises:
- o Moderately
- o Occasionally
- o Rarely
- o Regularly
- o Never

Patient Smokes:
- o 2+packs/day
- o 2 packs/day
- o 1 pack/day
- o ½+pack/day
- o 0-1/2pack/day
- o Never

Patient Uses Alcohol:
- o Excessively
- o Moderately
- o Occasionally
- o Rarely
- o Never

Medication you are taking:
- o Analgesics
- o Anti-Inflammatory
- o Birth Control
- o Hypertension
- o Muscle Relaxer
- o Tranquilizers
- o Psychotropic
- o No Non-Prescription
- o No Prescription

Auto Accidents:
- o 0 -1 years ago
- o 1 – 5 years ago
- o 5 or more years ago
- o Other Accidents

Please List All Operations & Surgeries

		Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

I understand the information I have provided above is current and complete to the best of my knowledge.

Signature: _____ Date: _____ HH/08/07-A

Name:_____ Date:_____

Chart#:_____

Neck Pain and Disability Index (Oswestry / condensed)

Please rate the severity of your NECK pain: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

How has your NECK pain affected you ability to manage your everyday life?

One answer per section.

Section 1 - Pain Intensity at this moment
- O A. No Pain
- O B. Mild Pain
- O C. Moderate
- O D. Fairly Severe
- O E. Very Severe
- O F. Worst Imaginable

Section 2 - Personal Care -
- O A. Without pain
- O B. Causes pain
- O C. Painful, I am slow and careful
- O D. Need some help
- O E. Need help doing everything
- O F. Do not get dressed and stay in bed

Section 3 - Lifting (I can lift heavy weight)
- O A. Without pain
- O B. It gives me extra pain
- O C. If conveniently positioned
- O D. Light weight if conveniently positioned
- O E. Lift very light weights
- O F. Cannot lift or carry anything

Section 4 - Reading (I can read)
- O A. No pain
- O B. with slight pain
- O C. With moderate pain
- O D. Can't read because of moderate pain.
- O E. Hardly read because of severe pain.
- O F. Cannot read at all

Section 5 - Headaches
- O A. None
- O B. Slight
- O C. Moderate-infrequently
- O D. Moderate - frequently
- O E. Severe - Frequently
- O F. All the time

Section 6 - Concentration
- O A. No difficulty
- O B. Slight difficulty
- O C. Moderate difficulty
- O D. A lot of difficulty
- O E. Severe difficulty
- O F. Cannot concentrate

Section 7 - Work
- O A. As much as I want
- O B. Usual work - no more
- O C. Some-no more
- O D. Hardly do any work
- O E. Cannot do my usual work
- O F. No work at all

Section 8 - Driving
- O A. No neck pain
- O B. Slight neck pain
- O C. Moderate neck pain
- O D. Limited / Moderate neck pain
- O E. Severe neck pain
- O F. Cannot drive

Section 9 - Sleeping (is disturbed)
- O A. No trouble
- O B. Slight (less than 1 hr.)
- O C. Mildly (1-2 hours)
- O D. Moderate (2-3 hrs.)
- O E. Severe (3-5 hrs.)
- O F. Completely (5-7 hrs.)

Section 10 - Recreation (I am able)
- O A. All activities - No neck pain
- O B. All activities some neck pain
- O C. Most activities - some neck pain
- O D. Few activities neck pain
- O E. Hardly any activities neck pain
- O F. No activities - neck pain

Low Back Pain and Disability Index (Rolland Morris / condensed)

Please rate the severity of your LOW BACK pain: ☺ 1 2 3 4 5 6 7 8 9 10 ☹

How has your LOW BACK pain affected your ability to manage your everyday life?

Check all that apply today
- O Stay at home most of the time
- O Change position frequently
- O Walk more slowly
- O Not doing any jobs around the house
- O Use a handrail to go up stairs
- O Lie down to rest more often
- O Hold on to get out of my chair
- O Get other people to do things for me
- O Get dressed more slowly
- O Only stand for short periods
- O Try not to bend or kneel down
- O Difficult to get out of my chair
- O Painful all the time
- O Difficult to turn over in bed
- O Appetite is not very good
- O Trouble putting socks on
- O Only walk short distances
- O Sleep less
- O Need help to get dressed
- O Sit down most of the day
- O Avoid heavy jobs
- O More irritable and bad tempered
- O Go upstairs slowly
- O Stay in bed most of the time

Patient Signature:

Date:

THE VILLAGE WELLNESS CENTER

Date:_____ **PATIENT INFORMATION** **CASE#:**_____

First _____ **Last** _____ **MI** ___ **Birth Date:** _____ **Age:** _____

Address _____ **SS#**_____

Zip _____ **City** _____ **ST:** _____ **E-Mail:**_____

Sex: M F **Marital Status: S M D W** **#Children:** _____ **Referred By:** _____

HM Phone: _____ **WK Phone:**_____ **Cell:** _____

Insurance Company: _____ **Policy Holders Name:** _____

Relation: Self Spouse Child Other **Policy Holder Birth Date:** _____ **Policy Holder Sex: M F**

Policy Holder SS# _____ **Policy Holder Employer:** _____

Your Occupation: _____ **Spouses Name:** _____

Past Chiropractic Care: Y N **Date:** _____ **Doctors Name:** _____

Are you now or have you ever been disabled? Y N **Service or Work** **When?** _____

Are your present problems due to an injury? Y N **Personal Injury** **On the job** **Auto Accident** **Other**

Has the accident/injury been reported? Y N **Employer** **Auto Carrier** **Other**

Have you retained an attorney? Y N **Firm Name:**_____

Attorney Name: _____ **Phone #:** _____

Please list any activities/hobbies you can't do as a result: _____

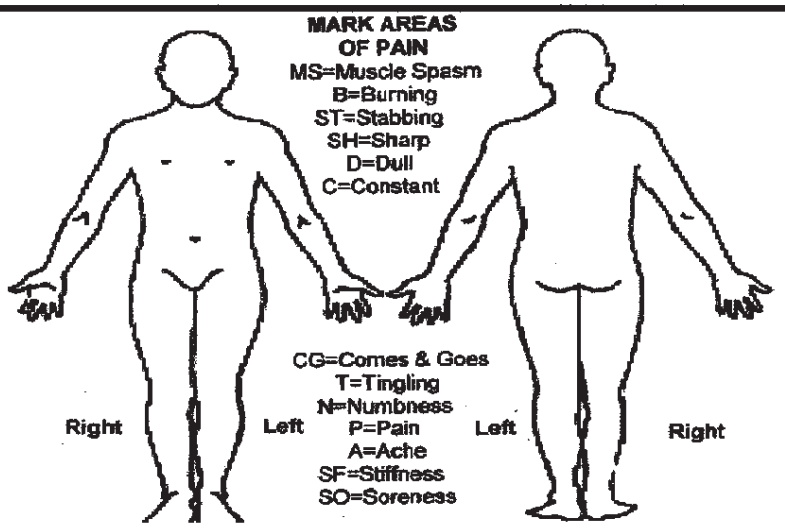
Please mark the intensity of your Pain
1= No Pain 10=Most intense pain ever felt

Example	*Neck*	*Duration How Long?*	*Previous Episodes?*
1 2 3 4 5 (6) 7 8 9 10		*2 months*	*Y N*

Chief Complaint	Duration How Long	Previous Episodes?
1)		
1 2 3 4 5 6 7 8 9 10		
2)		
1 2 3 4 5 6 7 8 9 10		
3)		
1 2 3 4 5 6 7 8 9 10		

Is there any possibility you could be pregnant?
Yes No **Date of last menstrual cycle:**

Please mark area & type of pain on the illustrations using the code list below



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.
I herby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for X-rays is for examination only , and that my X-ray negatives will remain the property of this office, being on file where they may be sent at anytime while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature X_____ Date:_____

PI/08/07-A

THE VILLAGE WELLNESS CENTER

HEALTH AND FITNESS PROFILE

This office functions as a Wellness Center. In order to fully address your personal needs, please answer the following questions.

1. Do you crave sweets, fats or carbohydrates (circle those that apply) Yes__ No__
2. Do you feel taking off a few pounds would benefit you? Yes__ No__
3. Do you have any hormonal concerns? Yes__ No_
4. Is an active lifestyle and sense of personal fitness important to you? Yes__ No__
5. Do you take nutritional supplementation (vitamins, minerals, herbs, etc.)? Yes__ No__
6. If yes, are you satisfied with the results of your products? Yes__ No__
7. If you do not take supplements, is this a health option you would consider? Yes__ No__

Any specific area not mentioned or other concerns?

_____

_____

_____

What medication(s) are you currently on? Please list all prescription and over the counter medications below:

_____

Medication Name	What Dosage? How many times a day	What illness/condition/syndrome Do you take it for:

The Village Wellness Center – Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed Massage appointments. Our policy is to charge for missed massage appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

THE VILLAGE WELLNESS CENTER

AUTHORIZATION FORM

This office utilizes an "**Open Treatment**" environment for ongoing patient care. "Open Treatment" involves the possibility of other patients being seen in the same "treatment environment" at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within hearing of other patients and staff. A private, closed and confidential setting is provided for history taking, examinations, report of findings, etc. as determined by the doctor and staff. The use of this format is intended to make your experience with our office the most efficient and productive and to further enhance your access to quality, principled chiropractic heath care and heath information.

If you choose not to be adjusted or use traction in an "Open Treatment" environment other arrangements will be made for you. Your decision will have no adverse affect on your care with The Village Wellness Center or your relationship with our staff. This office also requests the presence of your spouse or significant other at your Doctor's Report appointment for purposes of health education.

We are requesting your authorization due to various interpretations under Federal Law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "Open Treatment" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

Additionally this office may use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, other appointment issues, newsletters, flyers, birthday cards, thank you cards, health related meetings, and/or Advanced talks/classes. During the course of your care with The Village Wellness Center it may be the desire of our office to request the use of your name for our referral/thank you boards(s) and or obtain a patient testimonial or patient photo to promote chiropractic.

This authorization may be revoked by you, the patient, at anytime. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Your signature indicates your authorization.

Print Name: _____

Signature: _____ **Date:** _____

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THE VILLAGE WELLNESS CENTER

INFORMED CONSENT FOR TREATMENT

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I, _____ do herby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine, exercises and traction. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

- Soreness: it is common to experience muscle soreness during treatment
- Uncomfortableness : temporary symptoms (dizziness, nausea) can occur, but are rare.
- Fractures/joint injury: underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.
- Stroke: strokes from chiropractic adjustments are extremely are.

Treatment Results
I understand there are benefits associated with treatment including decreased pain, improved mobility and function and reduced muscle spasm. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact predictable science.

Alternative Treatment Available
Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercise, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions regarding treatment have been answered to my satisfaction.

Patient Signature:_____ Date: _____

Witness Signature: _____ Date: _____

Patient Status at Time of Consent:

( ) Of Legal Age
( ) Oriented
( ) Coherent/Lucid
( ) Proficient English
( ) Assisted by Interpreter
( ) Medicated, But Unimpaired
( ) Denies Use of Alcohol or Recreational Drugs Prior to Consent
( ) Unable to give Legal Consent
( ) Consent Given Via Legal Guardian

I certify that this form accurately reflects the patient's status during the informed consent process.

Doctor/Staff Signature:_____ Date:_____

THE VILLAGE WELLNESS CENTER

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patent for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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 of the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination 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 another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we my use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Signature: _____ Date: _____

Consent To Evaluate And Adjust A Minor Child:

I,_____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature:_____ Date: _____

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THE VILLAGE WELLNESS CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notices of Privacy Practices. I understand that this form will be placed in my patient file and maintained for six (6) years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

The Village Wellness Center a Chiropractic Place **Chart # _____**

OUR MASSAGE POLICY

In order to properly treat all of our patients and maximize your scheduled appointments minutes, your cooperation with these few, simple rules will help us be as efficient as possible:

- Please arrive 10 minutes prior to your appointment to allow time to sign in and remove your outer clothing. As a reminder, it is a law that all massage patients wear panties/briefs during their sessions.
- This is a Therapeutic Massage session, therefore treat it as any medical appointment where the work of the therapist is meant to bring about positive change. This requires the therapist to work and the patient to fully engage in the healing process.
- **Late policy:** If you arrive late, to honor the next patient's time slot, your session will end at the scheduled time and you will receive less minutes of therapy.
- **No-Shows will be charged a $25 fee.**

_____ _____

Patient Signature Date

The Village Wellness Center a Chiropractic Place Chart #: _____

Patient Name: _____

MASSAGE CLIENT FORM

1. Have you had a professional massage before? Yes No
2. What types of massage/bodywork have you had? _____
3. How long have you been receiving massage therapy? _____
4. Frequency of treatments? _____
5. What are your goals for treatment? _____

CURRENT HEALTH

6. Do you exerciser regularly and /or participate in any sports? Yes No
   If yes, which sports? _____
7. Have you recently suffered an injury? Yes No
   If yes, describe: _____
8. Have you had any areas of inflammation? Yes No
   If yes, describe: _____
9. Are you currently under the care of a physician? Yes No
   If yes, explain: _____
10. Have you had recent surgery? Yes No
    If yes, explain: _____
11. Medications/Allergies: _____
12. Any other medical conditions: _____

Health History	Yes/Current	Past	No
Contact lenses			
Dentures			
Back pain/Sciatica			
Spinal Problems			
Osteoporosis			
Broken bones			
Easy Bruising			
Skin Problems			
Allergies			
Varicose Veins			
Phlebitis/Blood Clots			
Heart Problems			
High/Low Blood Pressure			
Ulcer			
Tendonitis, bursitis, etc			
Arthritis or joint disease			
Diabetes			
Seizures/Convulsions			
Multiple Sclerosis			
Nerve Degeneration			
Cancer or Tumors			
Infectious Diseases			

Patient Signature: _____ Date: _____