POWDERSVILLE WELLNESS

At this office we have a high standard that we hold ourselves and our patients to. By answering the questions honestly, we will be able to better assist you and give you the highest quality care and a better experience:

Which of our treatment options are you interested in today (**Circle all that apply**):

Chiropractic	Regenerative Therapy	Functional Medicine
Relief *Pain relief, 12 visits*	**Platelet-Rich Plasma Injections** *Soft tissue injury*	**Diagnostic Blood Testing** *Thyroid panel, vitamin D, inflammation, allergy testing, etc.*
Spinal Correction *Relief and then correction to the spine, 30 visits, long term solution*	**Stem Cell Injections** *Knee pain, shoulder pain, arthritis, neuropathy*	**Supplementation and Vitamins**
Wellness *Monthly Maintenance, coming less often*		

1. On a scale of 0-10, how important is it that you fix the problem, starting today?

   0 being not important and 10 being the highest priority

   0 1 2 3 4 5 6 7 8 9 10

2. If we can find a way to make this treatment cost effective for you and your family and done in a timely manner, would you be interested in future care? Circle one: YES NO

3. If insurance does not cover this service, how would you be most interested in paying for your long-term treatment plan?

   Monthly Payment Plan Pay Up Front

4. Have you had pain in any of the following areas for more than 1 year? (**Circle all that apply**):

   Knee **Shoulder** **Wrist** **Ankle** **Neuropathy**

   How long have you had this pain?_____

Would you be interested in a free Stem Cell consult to discuss other treatment options? **YES** **NO**

Office use Only: NP Fee _____ *Whom may we thank for referring you to this office?* → _____

APPLICATION FOR CARE AT POWDERSVILLE WELLNESS

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ __Home Phone: _____
Mobile Phone:_____ Work Phone: _____
Do you have Insurance: ❑ Yes ❑ No
Primary Insurance Holder Name:_____Birth Date:_____Address: _____

PATIENT:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Social Security #: _____Driver's License #: _____

Employer: _____

Occupation:_____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____
Fourth: _____
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

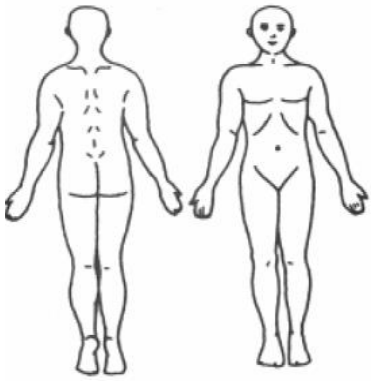
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM
How long does it last? □ It is constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? □No □ Yes **If yes,** when: _____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A = A**ching
N = Numbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? □ Yes, □ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:
_____
_____
_____

PAST HISTORY

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life

ACTIVITIES:	EFFECT:			
Carrying Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	❑ Unable to Perform
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Reading/Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

List Prescription & Non-Prescription drugs you take:

_____

_____

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Powdersville Wellness have been or will be explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Authorized person's/Guardian Signature Date Witness Initials

Powdersville Wellness' NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Powdersville Wellness's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

Social Media: I authorize and grant Powdersville Wellness to take my photos regarding my experiences with them. I grant Powdersville Wellness to use my photos on Facebook, Twitter, Instagram, and other social media platform. I allow them to edit, alter, copy, or distribute the photos for social media advertising and marketing. I agree that the photos belong to Powdersville Wellness. I understand that I will not receive any monetary compensation.

I am aware that a more comprehensive version of this "Notice" is available to me upon asking. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient signature Date

_____ _____ _____

Authorized person's/Guardian Signature Date Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on ____-____-____ Date

□I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*

Patient or Authorized person's Signature Date