WOLPH CHIROPRACTIC

123 S. Main St.- Fostoria
419.436.0616

640 S. Wintergarden- Bowling Green
419.353.6394

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____ Are you a military Veteran? Yes or No

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___ No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred. I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Wolph Chiropractic & Acupuncture** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Should my account ever become delinquent I agree to be responsible for all Lawyer fees, court costs, and interest charges resulting in the filing of a small claims case for a collection of a debt incurred at Wolph Chiropractic, Inc. I also agree to be responsible for a $50 charge for all returned checks for "Insufficient funds" per incident.

_____ _____

Signature of Insured/Guardian Date

HEALTH HISTORY

Date of Last: Physical Exam: _____ Spinal Exam: _____ Blood Test: _____

Please circle all that apply. Any further medical issues please explain on back of this page.

AIDS/HIV	Dizziness	Menopause	Shortness of breath
Diarrhea/Consti.	Tics/Spasm	Ringing in ears	Stroke
Migraines	Pain in Jaw	Multiple Sclerosis	Carpal Tunnel
Anemia	Gall Bladder Dis	Infertility	Thyroid Problems
Cold hands/feet	Fatigue	Osteoporosis	Tonsillitis
Appendicitis	Bladder Problem	Stomach Problem	Chest Pains
Arthritis	Gout	Parkinson's Dis.	Tumors
Asthma	Heart Disease	Pinched Nerve	Fibromyalgia
Breast Lump(s)	Hernia	Memory Loss	Vaginal Infect
Lung Disorder	Circulation Prob.	Seizure	Herniated Disk
Aneurysm	High Cholesterol	Prostate Problem	Musculoskeletal Disc
Cancer	Kidney Disease	Ear Infections	Muscle Spasms/weak
Eye Problems	Liver Disease	Psychiatric Care	Nervous/Anxiety
Menstrual Prob.	Weight Gain	Weight Loss	Bleeding Disorders
Numbness	Ulcers	Change in hair/skin/nails	

OTHER: _____

EXERCISE: NONE MODERATE DAILY HEAVY

Do you consider your health to be: POOR AVERAGE GOOD EXCELLENT

HABITS:

Alcohol/drinks per week: _____ Coffee/Caffeine Drinks per Day: _____

High Stress Level/Reason(s): _____

WORK ACTIVITY: Sitting Standing (Labor: Light Heavy Repetitive Lifting) High Stress

Strong Odors

ARE YOU PREGNANT? Y N **DUE DATE:** _____ **Difficult Pregnancy?** Y N

INJURIES:	**DESCRIPTION**	**DATE (APPROX)**
Falls:		
Head injuries:		
Broken bones:		
Dislocations:		
Other:		

LIST MEDICATIONS/VITAMINS/HERBS/MINERALS: _____

_____

Everything is listed accurately and to the best of my ability.

Print Name: _____

Signature: _____ Date: _____

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640 S. Wintergarden Rd., Bowling Green 419-353-6394

CURRENT CONDITION/PROBLEM

Name: _____ ID/Pol.# _____

Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

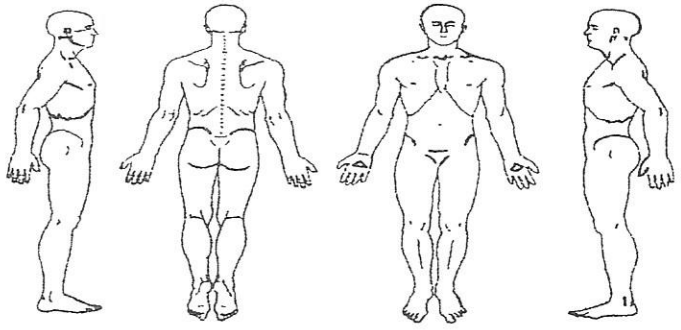
Condition / Problem	Severity (Minimal · Severe)	Frequency (% of week) (Occasional · Constant)
a. Cervical (neck)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. Thoracic (upper back)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. Lumbar (lower back)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. Hip(s)	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptom(s): Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
(circle all that applies)

e. Shoulder/Elbow/Wrist/Knee/Ankle	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptom(s): Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needle
(circle all that applies)

(Please mark the figures where you experience pain.)



Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

When did your symptoms begin (**date required by insurance co.**)? _____
How did your symptoms begin (**be specific**)? _____
Do your symptoms radiate (**pain spreads out**)? _____
Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
Circle the things that make your problems worse:
Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
If No, what have you tried that has not helped? _____
Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

Have you experienced this before and what year? Y/N _____, have you been treated for this before
(if yes, how long ago-date required) Y/N_____, what treatment did you receive_____,
results of previous treatment _____

List any other major injuries, illness, medical treatment or conditions you have had, other than those mentioned above:

_____
Have you ever had spinal or joint surgery? Y/N_____
Do you have any implanted devices such as defibrillator or pacemaker?_____

How did you hear about our office? _____

I certify that the above information is accurate to the best of my knowledge.
Patient/Guardian Signature _____ **Date:** _____

In ADDITION to Chiropractic care, we also offer other services:

1. I am interested in having MASSAGE THERAPY:
Yes No want more info

2. I am interested in having ACUPUNCTURE:
Yes No want more info

3. I am interested in the NUTRITIONAL EVALUATION:
Yes No want more info

WOLPH CHIROPRACTIC, INC.
123 S. MAIN ST., FOSTORIA, OH 419-436-0616
640 S. WINTERGARDEN RD., BOWLING GREEN, OH 419-353-6394

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Wolph Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle only one above) *(Circle only one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $31.50 - $63

Consent to Evaluate and Treat a Minor:

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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____