

ADULT WELLNESS INFORMATION

ABOUT YOU...

Today's Date: _____
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip: _____ Home phone: _____
 Birth date: _____ Mobile phone: _____
 Social Security # : _____
 Age: _____ Gender : _____ Number of children: _____
 Marital status: _____
 Employer: _____
 Work address: _____
 Work phone: _____
 Type of work: _____
Hours of employment: _____
E-MAIL ADDRESS: _____

Providing the above contact information including your address, home phone number and email address constitutes permission for us to communicate with you via these means.

ABOUT YOUR SPOUSE...

Name: _____
 Employer: _____
 Work phone: _____
 Type of work: _____

YOUR EXPERIENCE W/ CHIRO...

WHO referred you to our office: _____
WHERE did you get our actual phone number that you used to call for your appointment? _____
 Have you been adjusted by a chiropractor before? Yes No
 Reason for those visits: _____
DID YOUR PREVIOUS CHIROPRACTOR RECOMMEND A CARE PROGRAM TO HELP YOU MAINTAIN BETTER NATURAL WELLNESS YEAR ROUND?... Yes No
Doctor's name: _____
Date of last visit: _____

YOUR REASON FOR VISITING US?...

Describe your reason for this visit:

- #1. Wellness Care: _____
- #2. Head/jaw: _____
- #3. Neck: _____
- #4. Upper back/shoulders/arms/hands: _____
- #5. Mid-back/chest: _____
- #6. Internal organs: _____
- #7. Lower back: _____
- #8. Sacrum/tailbone: _____
- #9. Pelvis/hips/legs/knees/ankles/feet: _____
- #10. Other: _____

Is this visit directly related to a: Work Injury? Auto Injury?

PLEASE NOTE - we do NOT accept Medicare, Medicaid, Worker Comp, Auto or Personal Injury cases. If you are coming here as a result of any of those, please see the Front Desk Coordinator BEFORE continuing with these forms.

WHEN did your problem **FIRST** begin: _____

Has it: gotten better gotten worse stayed same

Does it interfere with your: Work Sleep Daily Routine

Has it occurred before? Yes No When: _____

Have you seen other doctors for it? Yes No

Doctor's Name (s) _____

Type of treatment: _____

Results: _____

What do you like to do when you are well and NOT working: _____

YOUR WELLNESS HABITS...

	Yes	No
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink caffeinated coffee/tea/soda?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use artificial sweeteners?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear: Heel lifts or Insoles?	<input type="checkbox"/>	<input type="checkbox"/>
Are they the same thickness?	<input type="checkbox"/>	<input type="checkbox"/>
How do you deal with stress?: _____		
Have You Taken ANY pain pills TODAY?	<input type="checkbox"/>	<input type="checkbox"/>

AWARENESS OF WELLNESS PRINCIPLES...

Did you Know:

That chiropractors work with the electric impulses that run your brain and body?

Yes No

That the electrical impulses that run EVERY part of your body and affect EVERY area of your life originate in your Brain STEM?... Yes No

That chiropractic is the largest natural healing profession in the world?

Yes No

That the vast majority of vitamins are synthetic and are made from coal tar?

Yes No

That Whole Food Vitamins are safer and more effective than synthetic vitamins?

Yes No

That your BLOOD TYPE can affect

Please list ALL ACCIDENTS (slips, falls & injuries) with dates:

What is your Blood TYPE? _____

Please list ALL ALLERGIES:

DRUGS YOU NOW TAKE...

Cholesterol medication Blood pressure medicine Stimulants Blood thinners Muscle relaxers

VITAMINS YOU NOW TAKE...

Please list ALL nutritional supplements (vitamins, minerals, herbs, etc.) that you are currently taking:

PAST & CURRENT HEALTH CHALLENGES...

Please check each of the health challenges that you are facing now or have faced in the past.

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Mid-Back Problems |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Shingles | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Congestion |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colds/Flu | |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision Problems | |
| <input type="checkbox"/> Problems between shoulder | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hearing Problems | |
| <input type="checkbox"/> High/Low Blood pressure | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Stiff Neck | |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Numbness Arms/Legs/Hands | <input type="checkbox"/> Ulcers/Colitis | | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Constipation/Diarrhea | | |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Tuberculosis | | | |

For Women Only:

Are you pregnant? Yes No
 Are you nursing? Yes No
 Are you taking birth control? Yes No

Please list ALL SURGERIES with dates:

Is your Blood PRESSURE: Low Normal High

Is your Blood SUGAR: Low Normal High

Is it OK to call you at your place of employment or on your cell phone to speak to you about your appointments or your health care information? If yes, what number can you be reached at: _____

Is it ok to leave messages on your home answering machine regarding your appointments? Yes ___ No ___

HOW DID YOU FIND OUT ABOUT OUR WELLNESS CENTER?...

Please **CIRCLE ALL** that apply:

People: _____ (Person's name, street & city)

Sign: on Building in Windows on Sidewalk

Alpena School System Calendar

Alpena School System Student Folder

Business Card

Flyer

Other: _____

Phone Book Ad: Yellow Book or Verizon **Which "heading":** Alternative & Complimentary Medicine
Chiropractors
Health Care Consultants
Health & Diet Foods – Retail
Massage
Nutrition Consultants
Spas – Beauty, Day & Health
Wellness Centers

Radio Ad: station and time of day: _____

TV Ad: channel and time of day: _____

Alpena News: Ad Business Brief

"Shoppers' Express" (Free newspaper) Ad

Direct Mail: Letter Postcard

Internet Search (**Which search engine**) - Google, MSN, Yahoo, Bing, etc.: _____

FaceBook

Website: www.AlpenaChiropractor.com

Massage Therapist: Name _____

Client Name: _____ **Date:** _____

WHAT ARE YOUR GOALS FOR YOUR CARE?...

Are you interested in **minimum RESULTS (Healing Chiropractic only)** or **MAXIMUM RESULTS (Comprehensive Natural Wellness - Relaxing Massage, Anti-Aging Nutrition & Skin Care and Healing Chiropractic)?**

_____ **Healing Chiropractic Only** _____ **Comprehensive Natural Wellness Care Plan**

TERMS OF ACCEPTANCE

Please Read **AND** Initial EACH Item

- #1. I understand that **NONE** of the **Natural Wellness SERVICES** (Chiropractic Consultations; Chiropractic Spinal Adjustments; Nutritional Consulting, Nutritional Evaluations; Nutritional Testing; Inter-Segmental Traction (IST) tables; Dry Hydrotherapy (DHT) tables; Spa Capsule Massage or Manual Massage) that are offered at or through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. _____
- #2. I understand that **NONE** of the **Natural Wellness PRODUCTS** (Whole Food Vitamins, Minerals, Herbs, Hormones, Skin Care, Body Care, etc.) that are offered through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. _____
- #3. I understand that it is my choice to see any other health care professional at any time (including a different type of chiropractor) – especially **IN ADDITION TO** continuing to utilize your services and products. _____
- #4. I understand that **NONE** of the doctors or therapists working here heals, nor do any of the services or products offered by them heal. The **ONLY** thing that heals is the life force that animates my body. _____
- #5. I understand that Kirk C. McAnsh, D.C., P.C. dba Maximum Performance Family Wellness Center disclaims any liability for consequential, incidental and punitive damages; express and implied warranties including but not limited to merchantability and fitness for a specific purpose; and any liability whatsoever in an amount greater than the amount paid by me or my insurance company or \$100, whichever is greater. _____
- #6. I understand that it usually takes 5 (five) adjustments over a 2 (two) week period in order for me to notice that my potential for enjoying life more has **STARTED** to improve. _____
- #7. I understand that it **USUALLY** take 12 (twelve) adjustments during my 4 (four) weeks of care in order for me to be well on my way to enjoying all areas of my life more. _____
- #8. I understand that I **MAY** “feel” worse (temporarily) as my potential for enjoying all areas of my life more starts to improve as a result of availing myself to the services and products offered by Maximum Performance Family Wellness Center. _____

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 disclosures for the purposes of care, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's 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:

- Conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians 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 you restrict how my personal information is used and/or disclosed.

FINANCIAL POLICY

I understand that MPFWC rates are as follows; New Client History & Consult - between \$50 & \$90; Spinal Adjustments - between \$20 & \$55 (depending on the number of areas adjusted, whether or not I have Medicare, or if I sign up for a SMARTcare Plan); IST (Roller Table) session is \$16.00 (\$12 if paid at time of service); DHT (Water Massage table) session is \$12 and that nutritional consulting, testing varies between \$35 and \$95 and Whole Food Vitamins vary between \$10 & \$127 - depending on my needs. I also understand that my insurance **will NOT** pay for the DHT, nutritional services & products and that if I want them that I will need to pay for those out of my own pocket.

I agree to pay in full at the time of each service unless I have insurance that will help support my care. My insurance policy may require me to pay a deductible each year and/or a co-pay for each service which I agree to pay for at the time of each service.

If I have an insurance policy that pays me directly, I agree to sign the back of each check and bring it (or mail it) to MPFWC **along with all of the paperwork that came with it**, within 7 days! Failure to do so will require me to pay for all services at the time of service from that point forward.

MPFWC does not accept payment or process claims from Auto Insurance, Personal Injury Worker's Compensation. We do not bill for these claims. I agree that the reason for my visit to this office is not a result of these type of claims.

I agree to pay MPFWC a \$5.00 Re-bill fee PER MONTH as well as a Service Charge of 7.0% A.P.R. on ALL balances 60 days and longer past due.

MPFWC agrees to bill my insurance company for me AS A COURTESY. However, if my insurance company has not paid within 90 days, the total amount due will be my responsibility, regardless of when I receive my statement from MPFWC or what my insurance company initially may have told MPFWC they would cover. **I understand that MPFWC can only estimate what my insurance will cover until an Explanation of Benefits or payment is received from my insurance company.**

I authorize Kirk C. McAnsh, D.C., P.C. to release any information to any insurance company, adjustor, agent or attorney that will assist in payment of a claim.

I agree to pay MPFWC \$22.50 "Return Check Fee" for any and all checks that do not clear the bank.

POLICIES & INFORMATION

I have received and read a copy of the following forms.

- * Terms of Acceptance
- * Notice of Privacy Policy
- * Financial Policy

I have received a copy of these policy's. I agree with them and will keep a copy for my records.

Signed

Date

Witness

Date