

ADULT WELLNESS RECORD

ABOUT YOU...

Name: _____
 Address: _____
 City: _____ State: _____
 Zip: _____ Home phone: _____
 Birth date: _____ Mobile phone: _____
 Social Security # : _____
 Age: _____ Gender : _____ Number of children: _____
 Employer: _____
 Work address: _____
 Work phone: _____
 Type of work: _____
 Marital status: _____
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: _____

EXPERIENCE W/ CHIROPRACTIC...

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 WHOLE BODY HEALTH YEAR ROUND?... Yes No
Doctor's name: _____

Date of last

REASON FOR YOUR VISIT...

Describe your reason for this visit:

Are you here today for Chiropractic, Nutrition or Both?...

Is this visit related to a:

Work Injury Slip or Fall Home Injury
 Other

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 the above listed, please see the front desk receptionist 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

Please explain: _____

Have you seen other doctors for it? Yes No

Doctor's Name (s) _____

Type of treatment: _____

Results: _____

HEALTH HABITS...

	Yes	No
Do you smoke (it slows your healing)?	<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"/>
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:

PILLS YOU NOW TAKE...

Cholesterol medication Blood pressure medicine Stimulants Blood thinners Muscle relaxers

NUTRITIONAL SUPPLEMENTS

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 a cell phone to speak to you about 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 or health care information? Yes ___ No___

How did you find out about our office?...

Please circle all that apply:

Friend _____ (Friend's name)

Business Card

Flyer

Other _____

Phone Book - Yellow Book

Phone Book - Verizon

Do you remember which phone book heading you found us under? _____

Radio: _____

Alpena News Ad

Direct Mail

Internet Search—Which Search Engine (Google, MSN): _____

Client Name: _____ Date: _____

YOUR GOALS FOR YOUR CARE?...

People see Chiropractors to be empowered for success as **THEY** define it. For some people, success is **less pain**, for others success is **better relationships, better performance in school, on the job or at your favorite sport or hobby**. Please check the type of care desired so that we may be guided by **YOUR** wishes whenever possible.

___ Our "Best" Recommendation ___ Our "Better" Recommendation ___ Our "Good" Recommendation

TERMS OF ACCEPTANCE

Important Facts to Understand **BEFORE** Being Accepted as a Client

Please Read **AND** Initial **EACH** Item

Natural Wellness Services and Products:

- #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; and Spa Capsule Massage unit) 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. _____
- #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 Dr. McAnsh does not heal, nor does any of the services or products offered by him heal. The **ONLY** thing that heals is my body. _____
- #5. I understand that it usually takes **5 (five) Brain STEM Adjustments over a 2 (two) week period in order for my body to start to improve it's function (health) to a noticeable level.** _____

NOTE: PLEASE BE ADVISED THAT IT CAN TAKE UP TO 12 BRAIN STEM ADJUSTMENTS DURING YOUR FIRST 12 WEEKS TO GET THE RESULTS YOU ARE HOPING FOR.

ALSO, PLEASE BE ADVISED THAT YOU MAY "FEEL" WORSE (TEMPORARILY) AS YOUR BODY BEGINS THE PROCESS OF RESTORING IT'S HEALTH.

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 discount pre-pay plan); IST (Roller Table) session is \$16.00 (\$10 if paid at time of service); DHT (Water Massage table) session is \$10 and that nutritional consulting, testing varies between \$30 and \$90 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 I will need to pay for those on my own.

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