Patient Name: ______________________________ Address ______________________________ Gender M F

City ___________________ State ____________ Zip Code ______ Email _________________________________

Home # ____________________ Work # _____________________ Cell # ________________________________

Best number and time to reach you _________________ Date of Birth _______________ SS# ____________

**To better serve you please fill out this form completely:**

1. What do you hope to achieve at Infinite Wellness? ________________________________________
2. How do you expect to achieve your hopes? ______________________________________________
3. What brought you into this office? ____________________________________________________

| List according to severity | Rate of Severity 1-10 | When did it start? | Have you had it before | Did it begin with an injury | % of time it is present |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

4. Check off any of the following symptoms that apply to you presently or have affected you in the past.

Headaches/Migraines
Sinus/Allergies
Chest/Rib Pain
Dizziness
Ear aches
Asthma
Frequent Colds/Flu
Heartburn/reflux
Low Energy/Fatigue
Weight Gain
Loss of Memory
Excess Gas/Bloating
Multiple Sclerosis
High Cholesterol
Bladder Problems
Digestive Problems
Infertility
Osteoporosis
Neck Pain

Shoulder Pain ( R or L)
Elbow Pain ( R or L )
Wrist Pain ( R or L )
Scoliosis
Low Back Pain
Mid Back Pain
Disc Problems
Insomnia
Ringing/Buzzing in Ears
Insomnia
Low Blood Pressure
Fibromyalgia
Shortness of Breath
Cancer
Indigestion
Kidney Disease
Hip Pain (R or L )
Knee Pain ( R or L )

Ankle Pain ( R or L )
Muscle Stress
Constipation
Hyperactivity
Arthritis
Stomach Problems
Depression
Bed Wetting
Menstrual Problems
Thyroid Problems
Blood Circulatory Problems
Nausea
Circulatory/Vascular Disorder
Heart Condition
Mood Swings
Urinary Difficulty
Chemical Stress

Physical Stress
Emotional Stress
Anxiety
Attention Disorders
Sciatica
Numbness/Tingling
Leg Pain ( R or L )
Arm Pain ( R or L )
Vertigo
Ulcers
Auto Immune Disease
Diabetes
Swollen Ankles
Skin Conditions/Acne
Diarrhea
Immune system Disorder

Other:__________

5. Which of the conditions you checked off is the worst for you ? ____________________________
   What do you believe is the cause of this condition? _____________________________________
   How long have you had it? ______ What are you currently doing for it? __________________
   Is the pain Sharp or Dull? ___Is it Constant or Occasional? ____Is it worse in the AM or PM?____
   Does it radiate into your arms or legs? ____________

6. Are any of these symptoms linked to a current car accident or workers compensation case? Y/N

7. Please check which aspects of your life are effected by your current level of health:

| | | |
|---|---|---|
| Bending | Weight/Metabolism | Job Performance |
| Lifting | Housework | Academic Performance |
| Walking | Yard work | Relations with significant other |
| Sitting | Travel | Sports |
| Climbing Stairs | Energy Levels | Physical Activities |
| Standing | Emotional well-being | Activities with friends |
| Running | Recreation | Ability to handle stress |
| Exercise | Memory | Overall Mood |
| Concentration | Patience/Temper | Family relationships |
| Focus | Relationships with kids | |

8. Do you have concerns about _____ Anxiety _____ Depression _____ Irritability?

9. On a scale of 1 to 10 ... how do you rate your overall health and well-being? ______________
   Where would you like it to be? _____ How long do you think it would take to get there? _____

10. Have you had any experience with chiropractic? YES NO
    Did you like the results you got? Yes NO
    What did you enjoy most about your visits there? ______________________________
    What did you like least about your visits there? ______________________________

How were you referred to us? ______________________________

Occupation ______________________________

Circle One: Single Married Divorced/Separated Widowed

Name of Spouse ______________________________
Name of Children and age(s) ______________________________

Education completed: High School College Graduate Post-Graduate

## Medical History

Please list all physicians and practitioners you have seen for your current condition:__________

______________________________

Have you had any surgeries? YES or NO If yes, when and what type? ______________

______________________________

Do you have any scars? YES or NO If yes, where? ______________________________

Have you ever been hospitalized? If yes, why?______________________________

Do you currently have any injuries due to an auto or work related accident? If yes, please

specify ______________________________________________

List any medical conditions you currently have ______________________________

______________________________________________

List any medications you are currently on ______________________________

______________________________________________

If there was a way we can help you get off these medications would you be interested? YES NO

Have you ever had any of the following diagnostic tests?

_____ X-rays _____ Bone Scan _____ Myelogram

_____ MRI Scans _____ CT Scan _____ EMG

If you have, please specify and list the reason why ______________________________

______________________________________________

**Are you currently pregnant?** YES NO

Are you a ____ Smoker _____ Non-Smoker

Do you drink alcohol? _____ Always _____ Occasional _____ Rarely _____ Never

How often do you exercise? _____ Always ______ Occasional ______ Rarely ______ Never

**Do you have a history of cancer?** YES NO If yes, please specify ______________

## Social/ Family Medical History

___Heart Disease ___Stroke ___Cancer ___ Blood Pressure __ Diabetes ___

Other ______________________________________________

## Additional Terms of Acceptance

We are committed to you, and helping you and your family understand your health condition. In order to achieve this, the following is our policy regarding going over your x-ray results. Should the doctor determine and your test reveal that you have subluxation, nerve damage, dysfunction, or any other serious conditions on your x-rays, **your spouse** will be **required** to attend the immediately next scheduled doctor's visit to discuss your exam and x-ray findings together. This is for your own safety and benefit, as we believe that it is crucial to have family support through your healing process.

In addition, it is important to have your spouse in attendance due to the vital decisions that will be made, including:

1. Treatment Options
2. Insurance and Financial Arrangements
3. Supportive Home Care

Having your spouse in attendance will prevent you from having to try to explain the results on your own to them, it will also prevent us from having to go over your results more than one time, saving time, preventing repeat work, and minimizing charges and costs to you. Your cooperation is greatly appreciated.

I have read and agree to the above additional terms of acceptance.

Name ______________________________ Signature ____________________________ Date ______________________

## 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 give permission for my child to receive chiropractic care.

Print Name _______________________ Signature _________________________ Date _________________

## Communications:

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

Spouse: _______________ Children __________________ Others _______________________________

## FOR WOMEN ONLY

**Pregnancy Release:**

This is to certify that to the best of my knowledge that I am NOT pregnant and the doctors and associates of Infinite Wellness and radiologists have my permission to perform an x-ray evaluation.

I have been advised that x-rays can harm a fetus ( unborn child ) in the early stages.

Date of Last Menstrual Cycle: ____________________ Signature _________________ Date __________

# Infinite Wellness

2 Berard Blvd. Oakdale, NY 11769

**Informed Consent:**

The chiropractic doctor provides a specialized, non-duplicating health care service which includes detecting and correcting spinal subluxation (a misalignment of one or more vertebrae causing a blockage in nerve flow). It is important to note that the chiropractic doctor cannot diagnose, treat, or cure any disease, although the doctors of Infinite Wellness are more than happy to work with other types of providers in your health care regimen.

I do hereby authorize the doctors of Infinite Wellness to administer such chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments, or any other chiropractic procedure which is advisable and necessary for my healthcare. I shall have an opportunity to discuss all chiropractic care that shall be necessary for my particular case. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated, however, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic doctor. I acknowledge that no guarantee can be made with respect to my treatment, and regardless of the outcome, I shall be responsible for all costs associated with my care.

In considering the amount of chiropractic expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Infinite Wellness, 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 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, reimbursements or any applicable remedies. 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 dull 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.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of seven percent (7%) per annum. I further acknowledge and agree that Infinite Wellness shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Infinite Wellness.

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.

I understand that Infinite Wellness has video recording equipment in the office for training purposes and to ensure that I receive the best possible care and experience. By signing below, I give permission to Infinite Wellness to video record my office visits. I shall have the option to revoke my consent upon giving written notice to the office manager.

**Acknowledgement:**

I have been informed that upon request I can receive a copy of the privacy (HIPPA)
And I am aware that I have an opportunity to discuss my rights to privacy if I please.

Print Name ____________________________ Signature ____________________________ Date __________