Please save the completed form and email it to frontdesk@panamacitywellness.com

Reset

GREEN WAVE FAMILY WELLNESS CENTER
625 Jenks Avenue Panama City, FL 32401
PanamaCityWellness.Com
Ph. 850-215-5657 Fax: 850-215-5658

CHIROPRACTIC PATIENT HISTORY

Date of Birth_____ Social Security Number: _____
Last Name_____ First Name: _____ Email Address _____
Address: _____ Apt # _____
City: _____ STATE: _____ Zip: _____
Phone (H) _____ (W) _____ (Cell) _____
Spouse's Name_____ (Cell) _____
Your Occupation: _____ Employer: _____
Employer Address: _____
Insurance Company _____ Policy Number: _____
Have you ever been to another doctor for this problem? Y N Who? _____
Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: Gradual: _____ Sudden: _____ Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb _____
- Does the Pain Radiate into your Arm _____ Leg _____ Other _____ Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

What Makes the problem worse? Sitting ___ Standing ___ Bending ___ Coughing ___ Lying down ___ Walking ___
Sneezing ___ Other _____

OTHER COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: Gradual: _____ Sudden: _____ Progressive over time: _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb _____
- Does the Pain Radiate into your Arm _____ Leg _____ Does not radiate _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): _____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

What Makes this problem worse? Sitting ___ Standing ___ Bending ___ Coughing ___ Lying down ___ Walking ___
Sneezing ___ Other _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE UNDERLINE ALL OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW

GENERAL SYMPTOMS

__ Headache
__ Fever
__ Chills
__ Sweating
__ Fainting
__ Dizziness
__ Convulsions
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Loss of Weight
__ Numbness or Pain in Arms, Hands, Legs
__ Allergy
__ Wheezing
__ Neuralgia

GASTROINTESTINAL SYMPT.

__ Poor Appetite
__ Difficult Digestion
__ Excessive Hunger
__ Belching of Gas
__ Nausea
__ Vomiting
__ Vomiting of Blood
__ Pain Over Stomach
__ Distention of Abdomen
__ Constipation
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids (Piles)
__ Intestinal Worms
__ Liver Trouble
__ Gall Bladder Trouble
__ Jaundice
__ Colitis

E.E.N.T.

__ Failing Vision
__ Nearsightedness
__ Farsightedness
__ Crossed Eyes
__ Eye Pains
__ Deafness
__ Earache
__ Noises
__ Ear Discharge
__ Nose Bleeds
__ Nasal Obstruction
__ Sore Throat
__ Hoarseness
__ Hay Fever
__ Asthma
__ Dental Decay
__ Gum Trouble
__ Frequent Colds
__ Enlarged Thyroid
__ Nasal Drainage
__ Tonsillitis
__ Sinus Infection
__ Enlarged Glands

DESIRED WEIGHT: (Significantly Below, Below, Good, Over, Significantly Over)
Struggled Weight Patterns: (Most of life, last 10 years, Last 5 years, Within last year)
Moderate to significant Mental Health or Relational Stresses (Yes or No)

CARDIO-VASCULAR

__ Rapid Beating Heart
__ Slow Beating Heart
__ High Blood Pressure
__ Low Blood Pressure
__ Pain Over Heart
__ Previous Heart Attack
__ Hardening of Arteries
__ Swelling of Ankles
__ Poor Circulation
__ Previous Stroke

MUSCLE & JOINT SYMP.

__ Neck Pain
__ Low Back Pain
__ Swollen Joints
__ Tremors
__ Foot Trouble
__ Painful Tail Bone
__ Hernia
__ Spinal Curvature
__ Faulty Posture

RESPIRATORY

__ Chronic Cough
__ Spitting up Phlegm
__ Spitting up Blood
__ Chest Pain
__ Difficult Breathing

GENITOURINARY SYMPT.

__ Frequent Urination
__ Painful Urination
__ Bloody Urine
__ Pus in Urine
__ Kidney Infection or Stones
__ Bed Wetting
__ Inability to Control Urine
__ Prostate Trouble

SKIN

__ Skin Eruptions
__ Painful Itching
__ Bruising
__ Dryness
__ Boils
__ Varicose Veins
__ Sensitive Skin
__ Hives or Allergy

FOR WOMEN ONLY

__ Painful Menstrual Periods
__ Vaginal Discharge
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Cramps or Backache
__ Previous Miscarriage
__ Vaginal Discharge
__ Congested Breast
__ Lumps in Breast
__ Menopausal Symptoms

ANY CHANCE OF YOU BEING PREGNANT?
YES_____ NO_____

PATIENT SIGNATURE: _____

DATE: _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Please list all past surgeries:

Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

_____
_____
_____
_____

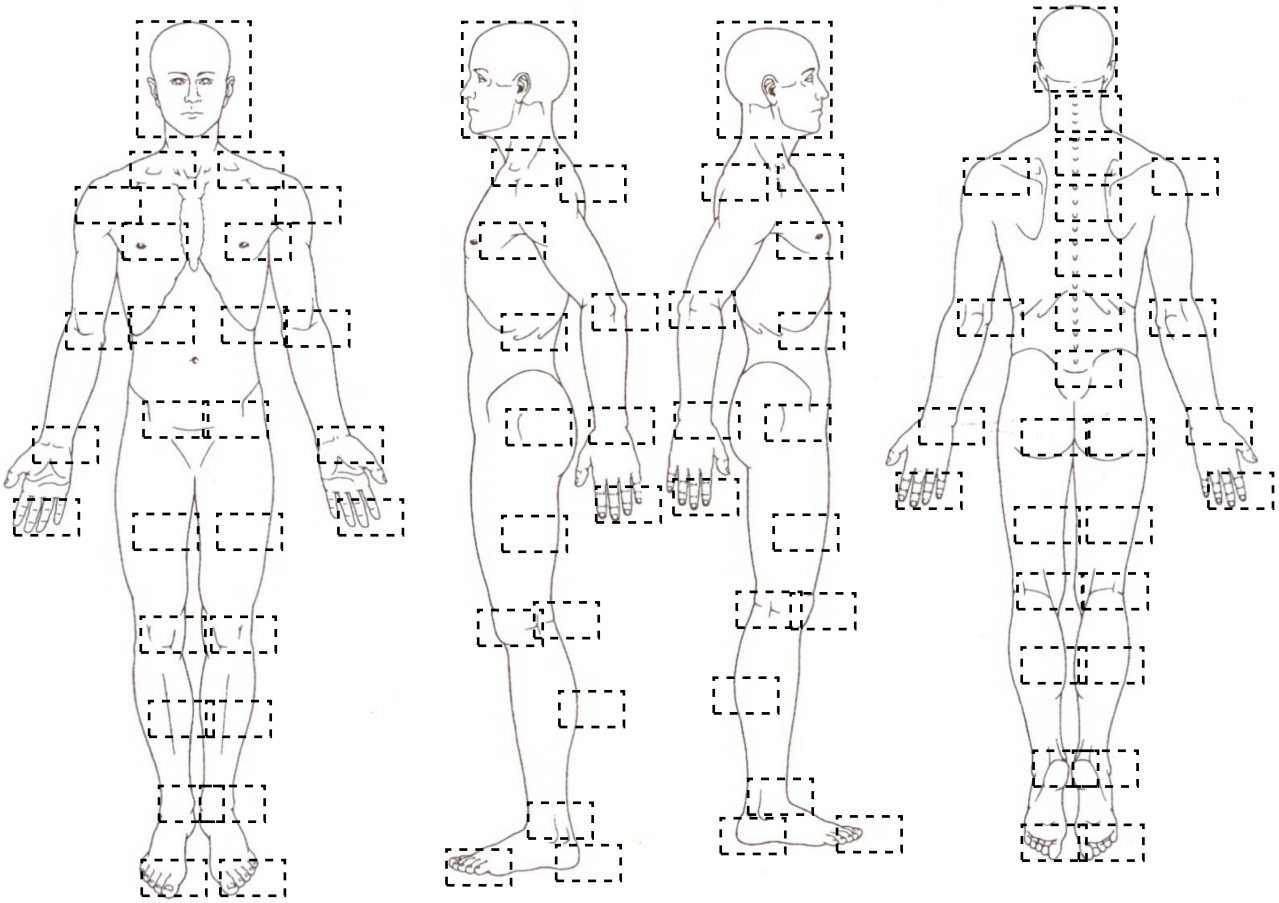
Please do not write in this section.

DOCTORS NOTES: _____
_____
_____
_____
_____
_____
_____
_____

PATIENT SIGNATURE _____DATE _____

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

P	**=**	**Where you experience Pain**
N	**=**	**Where you experience Numbness**
T	**=**	**Where you experience Tingling**
B	**=**	**Where you experience Burning**
C	**=**	**Where you experience Cramping**

Patient Signature: _____ Date: _____

GREEN WAVE FAMILY WELLNESS CENTER

OFFICE POLICIES

Patient-Doctor Agreements
The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results,

Signing In
When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries
In the event you sustain a new injury. Please let the front desk know as soon as possible. There may be additional paper work to be filed out.

Appointments
After your treatment, please be sure to stop at the front desk to take care of any co-pays or balances, and be sure to make your next appointment.

Payment of Bills
We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible unless told specifically this is not the case. Please also bring in the attached explanation of benefits (EOB).

Rescheduling Appointments
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day if possible. If the same day is not possible, be sure to make up the missed appointment within one week. **For our massage therapy patients and counseling patients, a 24-hour advance notice phone call is required, so that we may fill that slot. If 24 hours notice is not given a cancellation fee will be charged to your account.**

Progress Evaluations and Re-Examinations
Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

Upsets
We are here to serve YOU. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion etc.). We see your comments as helping us to help you and others.

Patient Signature_____ Date: _____

GREEN WAVE FAMILY WELLNESS CENTER

Informed Disclosure and Consent:
Chiropractic Spinal Adjustment Procedures and Physical Modalities

You have the right as a patient to be informed about your injuries and/or condition, as well as the doctor's recommended procedures and any necessary referrals to be utilized to evaluate and treat your complaints. There are potential risks and benefits in all forms of commonly used treatment, including deciding on non-treatment in the hope that the pain and/or lack of ability to perform normal activities will eventually go away. Evaluations at this office consist of a thorough regional examination of your complaints and any necessary diagnostic X-rays. If you are a female of child bearing age, you must inform the physician if there is even the slightest possibility that you may be pregnant (you must be sexually active and have missed a menstrual period), as X-rays can have harmful effects on a fetus. The physician will perform various Range of Motion and Orthopedic Stress Tests to determine the most likely cause of your pain and most appropriate course of treatment for each of your complaints. Your non-surgical spinal-related complaints will be treated with specific chiropractic spinal adjustment procedures using the hands or a mechanical instrument. You may feel joint movement and hear joint noises during the procedure. Minor temporary soreness may occur, particularly early in the treatment, or during periods of flare-up with your return to normal activities; this is also true of massage therapy and physical therapy. More significant risks (for example, fractures, sprains/strains, strokes and disc injuries) are rare. Chiropractors, or D.C.'s, have the lowest medical malpractice insurance claims of all primary care physicians in the USA, including M.D., D.O., D.D.S., D.V.M. and D.P.M. practitioners. The for-profit malpractice insurance industry has determined there is less risk involved in chiropractic spinal adjustment procedures and the adjunct therapies than in the prescribing of medication and surgery (both of which, however, may be necessary for a patient's recovery). I do not expect the doctor to be able to anticipate and explain all potential risks and complications, and I wish to rely on the doctor's education, training and experience to exercise judgment during the course of treatment, based on the facts then known, to do what is in my best interest. I further acknowledge that treatment may worsen or fail to relieve all of my spinal-related pain and that no guarantee of a "new spine" or complete cure have been given. I have had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the prescribed treatment plan and intend for this consent form to cover the entire course of treatment for my current complaints and for future conditions for which I seek treatment for my current complaints and/or therapists working at this office (or for the minor patient named below for whom I am the custodial parent or legal guardian).

Signature: _____ Date: _____

Printed Name: _____

If a minor (less than 18 years old), Parent or Guardian's name: _____

Parent or Guardian's signature: _____

GREEN WAVE FAMILY WELLNESS CENTER

Release Of Records / Payment Agreement
And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____Date:_____

I hereby authorize: Green Wave Family Wellness Center, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to Green Wave Family Wellness Center my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date: _____

Witness: _____ Date: _____

GREEN WAVE FAMILY WELLNESS CENTER

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (Please Print) _____ Date: _____

_____
Parent, Guardian, or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.