



New Client Chiropractic Paperwork

Please remember to bring this paperwork **completed**
to your New Client Chiropractic Appointment.

If your paperwork is not completed, you may be asked to reschedule your appointment.

Please contact our Client Advocate if you have any
questions or need additional information.

Chiropractic Patient Information

Patient Information

First Name _____ MI _____ Last _____
Home Phone _____ Cell Phone _____
Street Address _____
City _____ State _____ Zip _____
Email Address _____
Birthdate _____ Age _____ Marital Status: S M W D Number of Children _____
Occupation _____ Years on Job _____
Business Phone _____

Insurance Information

Do you have Medicare? _____ Is Medicare your Primary Insurance? Yes No
If Medicare is your Primary Insurance, please fill out Notice of Medicare Coverage for Chiropractic Care.
Is this an Auto Insurance case? Yes No
If this is an Auto Insurance case, please fill out Accident Insurance Information and History forms.

Note: For non-Medicare and non-Auto Insurance patients, full payment is due at the end of each visit.

In Case of Emergency, please contact:

Name _____
Relationship _____ Phone Number _____

Authorization for Chiropractic Services

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic does not offer to diagnose or treat any disease or medical condition. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire diagnosis or treatment of those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our practice objective is to eliminate interference to the body's innate healing capability. Our method of treatment is by specific adjustments to the spine and related joints, auriculotherapy, and healthy lifestyle recommendations.

Possible effects that may occur from chiropractic treatment are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

I, the undersigned, a patient in this office, hereby authorize Jon G. Gindhart, D.C. (and whomever he may designate as his assistants) to perform chiropractic and auriculotherapy procedures as considered necessary on the basis of findings during the course of said treatment.

Patient/Guardian Signature

Date

Financial Agreement

I agree to pay for services rendered to the above-mentioned patient as the charge is incurred and I understand and agree that I am personally responsible for payment of any and all services (that are not covered by Medicare or Auto insurance). I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

If you have out-of-network chiropractic benefits, we will gladly provide you with the necessary receipt and codes the insurance company will need to process your claim. However, we are not a mediator between you and your insurance company, as your contract is between you and them.

Patient/Guardian Signature

Date

Records Release

Jon G. Gindhart, DC, PC, is authorized to obtain, examine, and make copies of medical records, x-rays and reports pertaining to treatment of my condition. This authorization is valid until revoked in writing by me. A photocopy of this authorization and my signature has the same effect as the original.

Patient/Guardian Signature

Date

Health & History Questionnaire

Please list the main reasons you are seeking our help:

1. _____ How long have you had this? _____
2. _____ How long have you had this? _____
3. _____ How long have you had this? _____

How often are your symptoms present?

1. ___ 0-25% ___ 26-50% ___ 51-75% ___ 76-100%
2. ___ 0-25% ___ 26-50% ___ 51-75% ___ 76-100%
3. ___ 0-25% ___ 26-50% ___ 51-75% ___ 76-100%

Please check all of the following that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> History of recent infection | <input type="checkbox"/> Recent trauma |
| <input type="checkbox"/> Recent fever | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnancy (# of pregnancies ___ ; # of births ___) |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Abnormal weight ___ gain ___ loss |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Stroke; date _____ | <input type="checkbox"/> History of low/mid back pain |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> History of neck pain |
| <input type="checkbox"/> Numbness in groin/buttocks | <input type="checkbox"/> Arthritis; location: _____ |
| <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Alcohol use; mild ___ moderate ___ extreme ___ |
| <input type="checkbox"/> Aortic aneurism | <input type="checkbox"/> Drug use; mild ___ moderate ___ extreme ___ |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Tobacco use; mild ___ moderate ___ extreme ___ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Lyme disease; date of diagnosis: _____ |

Do you have a Pacemaker? _____ Could you be pregnant? _____

Family History

- Cancer
- High blood pressure
- Back problems
- Diabetes
- Cardiovascular problems/Stroke
- Scoliosis

History of Accidents: (broken bones, car accidents, hospitalizations, head injuries, etc.)

Surgeries: (procedure, date)

Medications: (medication and condition)

Notes:

Pain Diagram

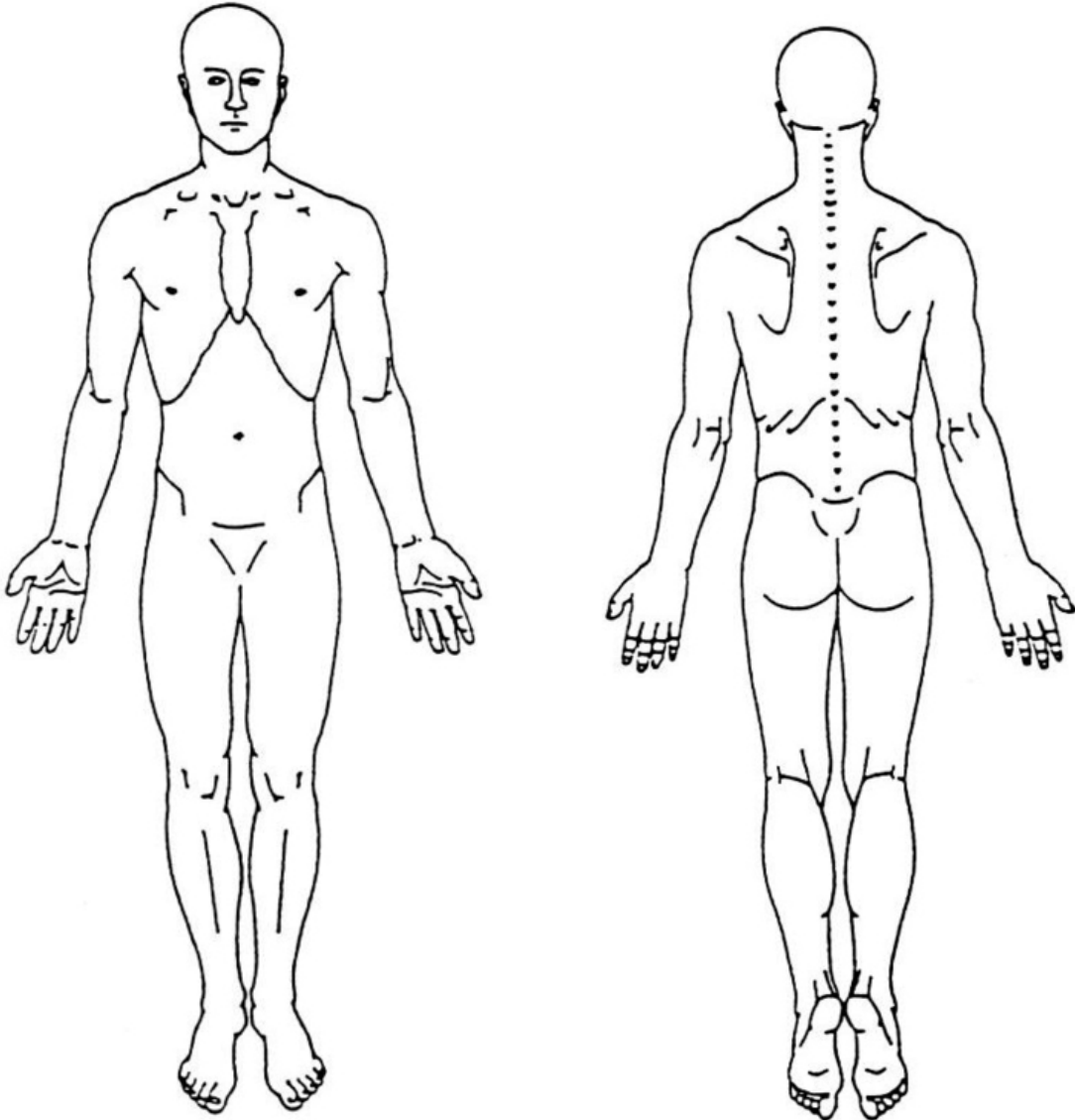
Instructions: Mark the location of your symptoms using these symbols:

Sharp Pain X

Numbness/Tingling +

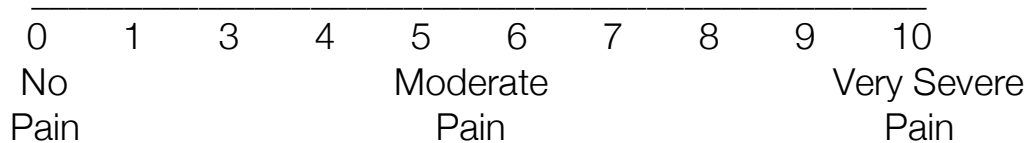
Dull Pain O

Other _____



Pain Scale

Instructions: Indicate your level of pain by choosing the appropriate number on the scale below:



Print Name _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

If there is a different address that we should send correspondence to, please list below:

Different Address: _____

AGREEMENT AND RELEASE OF LIABILITY

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by the clinicians or employees of the Well of Life Center for Natural Health, LLC is to be used for educational purposes only. I also acknowledge that neither Well of Life Center for Natural Health, LLC, Cynthia Hofmann, Tiffany Guerreiro, Anthony Blasco, Victoria Fisher, Felicia Pasquale nor any of the staff members at the Well of Life Center for Natural Health claim to be medical doctors and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition. Well of Life Center for Natural Health, LLC and its nutritional clinicians have been thoroughly trained and certified.

If I experience any changes in my health or current medications, I will immediately communicate this information to Well of Life Center for Natural Health, LLC. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Well of Life Center for Natural Health, LLC liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing is not a method for "Diagnosing" or "Treating" of any disease including conditions of cancer, AIS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs, modalities, and activities of Well of Life Center for Natural Health, LLC and to use its facilities in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Well of Life Center for Natural Health, LLC and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery. I do also hereby release all of these mentioned and any others acting upon their behalf from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Well of Life Center for Natural Health, LLC,

I have read and understand the foregoing. Intending to be legally bound, I hereby release the Well of Life Center from any liability, including for negligence, regarding my health matters and my participation in Nutrition Response Testing or any other program. This release applies to all subsequent visits for programs, modalities and activities at the Well of Life Center for Natural Health, LLC.

Client Name (print): _____

Client Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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