Welcome To Health and Wellness Alternatives!

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease." – Thomas Edison

Patient Demographics

Last Name:_____First Name:_____MI:____

DOB: ___/___/_____ Gender: _____ SSN_____-_____-_____

Weight:_____ Height:_____

Marital Status:_____ Employment Status:_____ Job Title:_____

Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Fax Number:_____Email:_____

Preferred Contact (*For Appointment Reminders*): (circle one) Home/Cell/Email

Employment Information

Employer Name:_____Employer Phone:_____

Address:_____

City:_____State:_____Zip:_____

Emergency Contact

Contact Name:_____Relationship to Patient:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Primary Insurance

Primary Insured ID:_____Insurance Name:_____

Last Name:_____First Name:_____MI:____

Patient Relationship to Primary Insured:_____

Subscriber ID:_____Group Number:_____

Secondary Insurance Information (*if applicable*):_____

Symptoms

Reason for Visit:_____When Symptoms Began:_____
Is the condition getting worse?_____Where is problem located? (specific):_____
Which activities are difficult to perform?
[ ] Sitting [ ] Standing [ ] Walking [ ] Lying Down [ ] Other _____
Type of Pain:
[ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Shooting [ ] Burning [ ] Tingling
[ ] Cramps [ ] Stiffness [ ] Swelling [ ] Other _____
Severity of Pain (1=mild, 10=severe): 1 2 3 4 5 6 7 8 9 10
Is the pain constant? When does it occur?_____
What Treatment Have You Already Received?
[ ] Medication [ ] Surgery [ ] Physical Therapy [ ] Other_____
Name/Contact Information For Doctor(s) Who Have Treated You For You Condition:_____
_____

Health History

Check Conditions Which Are Applicable:
__AIDS/HIV __Vaginal Infections __Herpes __Miscarriage __Breast Lump __Suicide Attempt __Depression __Bulimia __Alcoholism __Anorexia __Chemical Dependency __Psychiatric Care __Hernia __Pacemaker __Thyroid Problems __Chicken Pox__Herniated Disc __Parkinson's Disease __Tonsillitis __Anemia __Pinched Nerve __Tuberculosis ___Diabetes __Hepatitis __Mumps __High Cholesterol __Pneumonia __Tumors,Growths __Appendicitis __Emphysema __Kidney Disease __Polio __Typhoid Fever __Arthritis __Epilepsy __Liver Disease __Prostate Problems __Ulcers __Asthma __Fractures __Measles __Prosthesis __Bleeding Disorders __Glaucoma __Osteoporosis __Migraine Headaches __Venereal Disease __Allergy Shots __Cataracts __Goiter __Rheumatoid Arthritis __Whooping Cough __Bronchitis __Gout __Mononucleosis __Rheumatic Fever __Heart Disease __Multiple Sclerosis __Cancer __Stroke __Scarlet Fever __Other
:_____
Date of Last Health Exam:__/__/_____ Surgeries You Have Had/Dates They Occurred:_____
_____
All medications Currently taking:_____Allergies:_____
Women~ Are You Pregnant? Y / N Nursing? Y / N Taking Birth Control? Y / N

Daily Habits

Level of Daily exercise? [ ] None [ ] Moderate [ ] Heavy Specify:_____
Vitamins/ Nutritional Supplements?_____Do You Smoke? If So, How Much?_____
How Much Liquor do You Consume Daily?_____Coffee/Caffeinated Beverages Daily?_____

Authorization

I certify that I have read and understand the above information and have accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient (Or Parent If A Minor):

X_____DATE _____

INFORMED CONSENT

I, the undersigned, have voluntarily requested that the doctor assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that the doctor is a chiropractor and that her services are not to be construed or serve as a substitute for standard medical care. The doctor recommends that I undergo regular routine medical check-up by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustment involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine chiropractic examination and treatment involve some of the following methods:

- Observation: General assessment/appraisal in all postures.
- Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) body parts may be viewed. Women may continue wearing their bra in the course of examination unless it obscures visualization/viewing of injured/abnormal body parts. You may request an observer be present at any time during examination and/or treatment.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Using a rubber hammer and tapping on bones or tendons
- Orthopedic/neurological testing: These are standard tests to assess your neuro-musculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment

Soreness: I am aware that like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Flores if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as normal dose of Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible never damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to the Informed Consent document.

_____ _____

Patient's Signature Date

I explained the procedures, alternatives, and risks in conference with the patient.

_____ _____

Doctor's Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(Print Name)

Signature: _____ Date: _____