Chiropractic Wellness Center, Dr. Marc Terebelo
30555 Southfield Rd., Suite 155, Southfield, MI 48076
Phone: (248) 593-8282 Fax: (248) 593-8284

Patient Information **Date: _____**

Name: _____ Age: ____ Preferred Name: _____

Date of Birth: _____ Gender: ____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home):_____ (cell):_____ (work):_____

Occupation: _____ Employer: _____

Referred By: _____

Marital Status: _____ Spouse's/Partner's Name: _____

Number of Children: ____

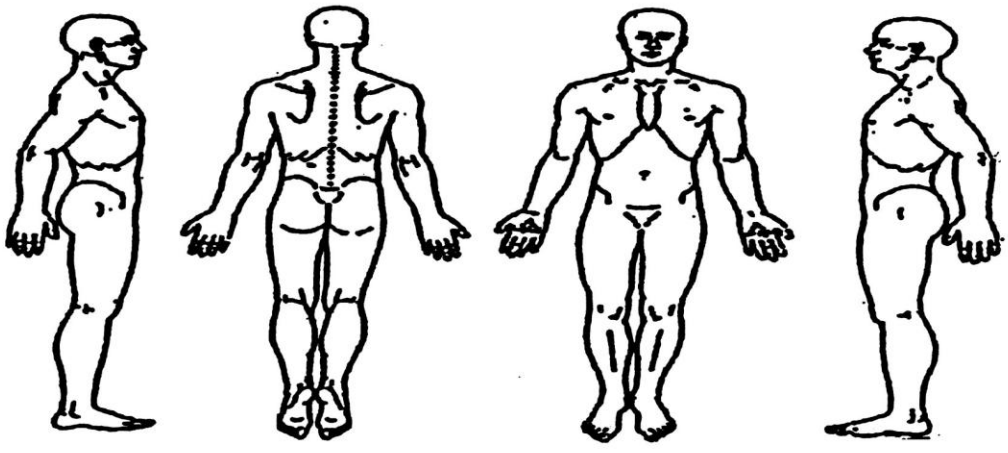
Email Address: _____

Guarantor's info if different: name/date of birth/address/phone number

_____

1. What is your chief complaint: _____

2. Indicate on the drawings below where you have pain/discomfort



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4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric-like with motion
□ Other:_____

5. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

6. How long have you had this problem? _____

7. What is your: Height_____ Weight _____

8. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

9. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Condition		Past	Present	Condition
		Headaches				Kidney Disorders/Stones
		Neck Pain				High Blood Pressure
		Upper Back Pain				Heart Attack
		Mid-Back Pain				Chest Pains
		Low Back Pain				Stroke
		Shoulder Pain				Angina
		Elbow Pain				Diabetes
		Wrist/Hand Pain				Epilepsy
		Leg Pain				Prostate Problems
		Knee Pain				Bladder Infection

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Patient Name

Past	Present	Condition	Past	Present	Condition
		Epilepsy			Systemic Lupus
		Hip Pain			Bladder Control
		Gall Bladder Issues			Depression
		Visual Disturbances			Anxiety
		Condition			Condition
		HIV/AIDS			Arthritis
		Drug/Alcohol Use			Cancer
		Smoking			Tumor
		Allergies			Asthma
		Jaw Pain			Hepatitis
		Birth Control			Pregnancy
		Ulcers			Gastric Reflux
		Dizziness			Memory Loss

10. List all nutritional supplements you are currently taking:

_____

11. List all surgical procedures you have had:

_____

12. Have you ever been hospitalized? □ No □ Yes

Describe: _____

13. Anything else pertinent to your visit today? _____

_____

Treatment Authorization

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt or will be returned to the insurance company and re-issued to the patient, if applicable. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor's office to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medical diagnosed conditions nor for any medical diagnosis.

Missed Appointment Fee: I agree to pay a **$25 fee** if I do not change or cancel my scheduled appointments with at least 24 hour notice prior to my scheduled appointment time.

Patient/Guardian Signature_____**Date**:_____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that 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 treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)**

_____

_____

_____

Staff signature **Date**

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Name: _____ **Preferred Language**: English Other

Date: _____ **Race**: American Indian or Alaska Native,

Cell: _____ Asian, Black or African-American, White

Other: _____ Hispanic or Latino, Multi-Racial, Other

Ethnicity: **Hispanic** **Not Hispanic**

Preferred method of telephone contact: _____

Email address: _____

Please list any/all medically prescribed medications you are taking at this time and precise dosage per day in mg.

1. _____**Strength**_____**Frequency**_____
2. _____"_____"_____
3. _____"_____"_____
4. _____"_____"_____
5. _____"_____"_____
6. _____"_____"_____
7. _____"_____"_____
8. _____"_____"_____
9. _____"_____"_____
10. _____"_____"_____

Do you have any Allergies? Yes_____ No_____

Medicine Severity: Mild/Mod/Severe Describe Reaction

_____
_____
_____

Do you use any form of tobacco? (age 13 and over) Yes_____ NO_____ What type?_____
If Cigarettes or cigars, how many do you smoke per day?_____

Height_____ Weight_____ ***Doctor Use Only: BP:***

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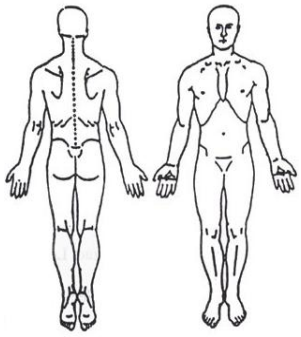
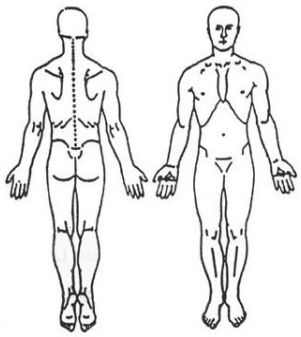
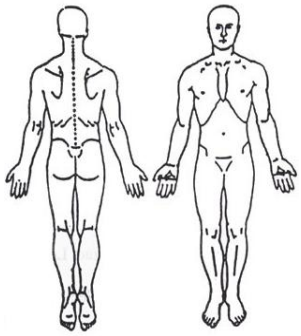
NAME_____**DATE**_____

PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED

Sprains/Strains, Broken Bones, Sever Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, etc.







What happened?	When did it happen?
What happened?	When did it happen?
What happened?	When did it happen?

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment of an adjustment include restoring normal join motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and /or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that a chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care of not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for our condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstances. I intend this consent to cover my entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature: _____ Date:_____

Parent or Guardian:_____ Signature: _____ Date:_____

Witeness Name:_____ Signature :_____ Date:_____