Positive Health and Wellness

WELCOME!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form to the best of your ability. If you have any questions, we will be happy to assist you. We look forward to working with you.

PATIENT INFORMATION

Name: ____
Last *First* *Initial*

Street Address: ____

City: ______________________ State: ___________ Zip: ___________

Telephone No.: (________) __________ - __________ Home Cell

(________) __________ - __________ Home Cell

Email: ____

Date of Birth: _____ / _____ / _____ M F

Marital Status: Single Married Divorced Widowed Other

Employer: ______________________ Occupation: ______________________

Address: ______________________ Telephone No: (_____) ______________

Whom may we thank for referring you? ______________________________

PRIMARY INSURANCE

Policy Holder's Name: ____

Relationship to Patient: ____

Address (if different from patient): ____

Employer: ______________________________ Telephone No: (   ) __________

Insurance Company: ______________________ Telephone No: (   ) __________

ID No.: ______________________ Group No.: ____________ Member No.: ______

Person financially responsible for account: ___________________________________

Relationship to patient: ____

Name of Primary Care Physician: ____

Primary Care Physician telephone number: _____________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____

Emergency Contact telephone number: ____

Relationship to patient: ____

REASON FOR VISIT

Chiropractic ________ Nutrition ________ Other: ____________________________

Have you ever treated with a chiropractor? Y N Name: ____________________________

Have you ever treated with a Nutritionist? Y N Name: ____________________________

Describe your current symptoms: ____

Date symptoms began: ____/____/_____

How often do you experience these symptoms? ____________________________________

Activities or movements that are painful to perform (Please check all that applies):

- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Other: ___________
- ❑ Lying Down
- ❑ Lifting
- ❑ Running

Type of pain (Please check all that applies):

- ❑ Aching
- ❑ Burning
- ❑ Cramping
- ❑ Other: ___________
- ❑ Cramping
- ❑ Numbness
- ❑ Sharp
- ❑ Stiffness
- ❑ Swelling
- ❑ Throbbing

If you suffer from numbness, in which area(s)? ______________________________

If you suffer from muscle spasms, in which area(s)? ______________________________

If you suffer from tingling, in which area(s)? ______________________________

Date pain began or date of injury: ______________________________

Where were you and what were you doing when pain began or injury occurred? ___________________

Have you had a similar condition in the past? Y N

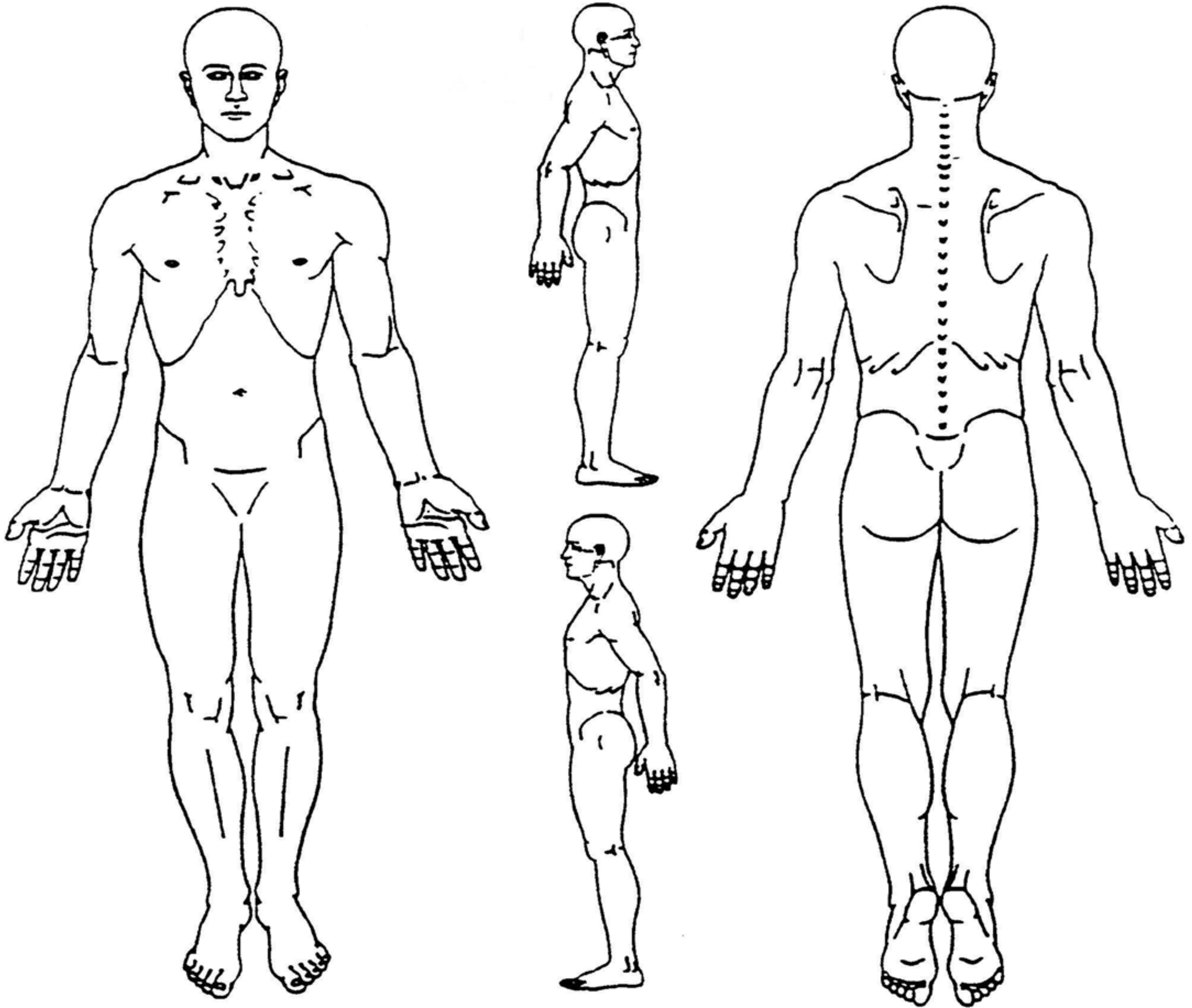
If yes, please explain: ______________________________

Is your pain interfering with: Work _____ Sleep _____ Daily Routine _____ Recreation _____

USE THE LETTERS LISTED BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN.

KEY

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS AND NEEDLES
S = STABBING
O = OTHER



PAIN SCALE

Please rate your current pain level on a scale of 0 – 10

0 = No Pain 10 = Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Do you have or have you had any of the following diseases or conditions:

- ❑ Alcohol/Drug Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones, Joints, Implants
- ❑ Artificial Valves
- ❑ Asthma
- ❑ Cancer
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Emphysema
- ❑ Fainting, Seizures, Epilepsy
- ❑ Frequent Neck Pain
- ❑ Glaucoma
- ❑ Heart Attack or Stroke
- ❑ Heart Surgery
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV+, AIDS, ARC
- ❑ Hyper/Hypo Thyroid, Hashimoto's
- ❑ Kidney or Liver Disease
- ❑ Low Back Pain
- ❑ Low Blood Pressure
- ❑ Frequent Severe or Migraine Headaches
- ❑ Mitral Valve Prolapse
- ❑ Psychiatric Problems
- ❑ Rheumatic Fever
- ❑ Shingles
- ❑ Sinus Problems
- ❑ STDs
- ❑ Tuberculosis
- ❑ Ulcerative Colitis/Gastric Issues
- ❑ Other: ____________________________________
  ____
  ____
  ____
- ❑ None of the Above

Please list all medications you are currently taking including all prescription medications, OTC medications, vitamins, herbs, supplements, etc.:

____

____

____

Do you have any known allergies? Y N

If yes, please explain: ____

____

____

____

____

Please list any serious injuries or surgeries within the last 10 years including dates:

____

____

____

____

____

Do you smoke? Y N If yes, how much? ______________________________

Do you exercise? Y N If yes, how much? ______________________________

Are you currently dieting? Y N

If yes, please explain:____

____

Do you have any of the following?

❑ Shoe lifts ❑ Inner soles ❑ Arch supports ❑ Custom Orthotics

Women Only: Are you pregnant? Y N If yes, how many weeks? __________
Are you nursing? Y N

Do you take birth control pills? Y N Do you take hormone replacements? Y N

Name of OB/GYN: ____

Positive Health & Wellness
Disc Centers of America
John N. Zilliox, DC CDN

AUTHORIZATION FOR TREATMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by John N. Zilliox, DC CDN (Dr. Zilliox herein) to help determine appropriate and healthful treatment. I agree to inform Dr. Zilliox of any changes in my medical status while under his care.

I authorize my health insurance company to pay Dr. Zilliox all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature below on all insurance submissions.

I authorize Dr. Zilliox to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I further understand that I am responsible for all charges not covered by my health insurance.

Patient Signature ___________________________________ Date _______________________

Health insurance covers chiropractic care ONLY.
We accept Blue Cross Blue Shield, Community Blue, and Independent Health.
Payment is due in full at time of treatment unless prior arrangements have been approved.

Positive Health & Wellness
Disc Centers of America
John N. Zilliox, DC CDN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of chiropractic procedures will be available in your medical record to all healthcare professionals who may provide treatment to you or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payments from your health plan, from other sources of coverage, such as an auto insurer or from credit card companies that you may use to pay for services.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the public health department.

OTHER USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: Other disclosures of your health information or for the uses other than those listed above, requires your written authorization. If you change your mind after authorizing, you may submit a written revocation of the authorization. However, your revocation will not affect or undo any use or disclosure that occurred before you notified us of your decision.

INDIVIDUAL RIGHTS:
You have certain rights under privacy standards including:

1. The right to request restrictions on the use and disclosure of your health information;
2. The right to receive confidential communications concerning your medical condition and treatment;
3. The right to inspect and copy your health information;
4. The right to request an amendment or submit a correction request to your health information;
5. The right to receive an accounting of how and to whom your health information was disclosed;
6. The right to receive a printed copy of this notice.

We are required to maintain the privacy of your health and to provide you with this notice of privacy practices.

We reserve the right to amend or modify our privacy policies and practices. Upon request, we will provide you with the most recent revised notice for any office visit. The revised policies and practices will be applied to all protected health information we maintain.

You may generally inspect or copy your health information. As permitted by health regulation, we require that such a request must be submitted in writing to our office.

Effective: September 29, 2006

I have read and understand my rights as outlined in the above Privacy Practices.

____ Date: ______________________
Patient Signature