WOODS
Chiropractic & Functional
Health Center, PSC

Name____ Date________________

Address______________________ City______________ State__________ Zip________

Home phone________________ Cell Phone________________ Work Phone________________

Email address ________________________________ Sex M/F Age ________

DOB ________________ SS# ________________________ Marital Status/ S M D W

Occupation ________________________ Employer ________________

Work Address ____

If applicable:

Parents/Legal Guardians Name ________________________________

Address____

Home phone ________________________ Work Phone ________________

No. of Children ________________________

How did you hear about our office? ________________________________

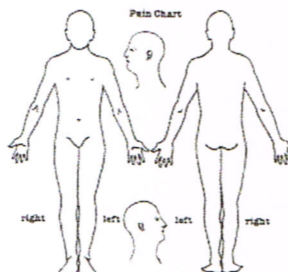
Main Complaint

1. What is your major symptom? ________________________________
2. What does this prevent you from doing or enjoying?________________________________
3. What is your treatment goal? ________________________________
4. If this is a recurrence, when was the first time you noticed the problem? ________________
5. How did it originally occur?________________________________
6. Has it become worse recently? Yes__________ No__________ Same__________ Gradually Worse__________
   If yes, when and how? ________________________________
7. How frequent is the condition? Constant ________ Daily ________ Intermittent ________ Night Only ________
8. How long does it last? All Day__________ Few Hours __________ Minutes __________
9. How many days have you lost from work due to these symptoms? ________________
10. Are there any other conditions or symptoms that may be related to your major symptoms Yes ________ No ________. If yes, describe________
11. Are there other unrelated health problems? Yes________ No________ If yes, describe________________
    Describe the pain: Sharp______ Dull______ Numbness______ Tingling______ Aching______ Burning ______ Stabbing ______
    Other ________________________________
12. Is there any thing you can do the relieve the problem? Yes_____ No_____. If yes, describe________________
    ________________. If no, what have you tried to do that has not helped?________________
13. What makes the problem worse? Standing ______ Sitting ______ Lying ______ Bending______ Lifting_____ Twisting_____ Other________
14. Have you had any broken bones? Yes_____ No_____. If yes, please list and give dates________________
15. List any major accidents you have had other than those that might be mentioned above: ________________
16. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ________
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes____ No____ Uncertain ____
    Remarks: ________________________________

No Pain ____ Unbearable Pain

Please place an "X" on the line above to indicate level of problem.

Show area(s) of pain or unusual feeling, pain or discomfort.



Past History

Past Chiropractic care / doctor's name ______________________________

Family physician ______________________________ Medications ______________________________

Surgeries / dates ______________________________

Illness / abnormalities ______________________________

Previous Injuries & accidents / dates ______________________________

Do you have difficulty with any of the following?

- ❑ Headaches
- ❑ Shooting head pains
- ❑ Sinus Trouble
- ❑ Loss of smell
- ❑ Hayfever
- ❑ Asthma/allergies
- ❑ Loss of taste
- ❑ Tightness in throat
- ❑ Inflammation of throat
- ❑ Thyroid Trouble
- ❑ Face flushed
- ❑ Twitching of face
- ❑ Loss of memory
- ❑ Fatigue
- ❑ Depression
- ❑ Head feels too heavy
- ❑ Weight gain
- ❑ Fainting
- ❑ Loss of balance
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Light bothers eye
- ❑ Muscle spasms in neck
- ❑ Grating in neck
- ❑ Tightness of shoulder muscle
- ❑ Neuritis in shoulders & arms
- ❑ Pins & needles in hands
- ❑ Cold hands
- ❑ Chest pains
- ❑ Shortness of breath
- ❑ Heart attacks
- ❑ Heart pain
- ❑ Heart palpation
- ❑ Weight loss
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Anemia
- ❑ Rheumatic Fever
- ❑ Nervous stomach
- ❑ Stomach trouble
- ❑ Ulcers
- ❑ Nerves & nervousness
- ❑ Inner tension
- ❑ Irritability
- ❑ Cold sweats
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Indigestion
- ❑ Intestinal gas
- ❑ Constipation
- ❑ Bladder Trouble
- ❑ Menstrual cramps & pain
- ❑ Menstrual Irregularity
- ❑ Diabetes
- ❑ Cancer
- ❑ Sleeping problems
- ❑ Painful joints
- ❑ Swollen joints
- ❑ Arthritis
- ❑ Slipped disk
- ❑ Pinched nerves in back
- ❑ Pins & needles in legs
- ❑ Swollen ankles
- ❑ Cold feet
- ❑ Pains in legs & feet
- ❑ Kidney trouble

Family Medical History

Breast cancer
Osteoporosis
Alzheimer's
Other cancers
Alcoholism
Diabetes
Cardiovascular disease
Mental illness/Depression
Arthritis
Stroke
Obesity
Allergies

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you circled in this section above.

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are the major causes? Work Family Finances Relationships Emotions

Other ______________________________

I eat the following: Sweets Cereals Sodas/Pop Legumes Ice cream Fruits Fried foods Vegetables

List your 4 favorite foods: ______________________________

This applies to me: Diet frequently Skip meals Dine out regularly

Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning, Noon, Night, Constantly snacking

Do you:

-use tobacco? YES or NO If yes, how much daily? ______________________________

If no, did you ever? YES or NO if yes how long? ______________________________

-Are you exposed to second hand smoke YES or NO If yes, how much daily? ______________________________

If no, did you ever? YES or NO if yes how much? ______________________________

-drink coffee? YES or NO If yes, how much daily? ______________________________

If no, did you ever? YES or NO if yes how much? ______________________________

Is it - strong mild decaf?

-eat chocolate? YES or NO If yes, how much daily? ______________________________

-drink alcohol? YES or NO If yes, how many ounces a day/ week? ______________________________

If no, did you ever? YES or NO if yes how much? ______________________________

How long did you drink before you stopped? ______________________________

-restrict your intake or avoid completely:

Fiber Dairy products Salt Animals protein Sugar All animal foods Fat

Exercise

Exercise weekly? YES or NO If yes, how many times per week? ______________

I agree that the information I provided is correct ______________________________

FAMILY MEDICAL HISTORY

Has anyone in your **family** been treated for the following?

CONDITION	YES	NO		CONDITION	YES	NO
1) Arthrits/Rheumatoid				13) Hepatitis		
2) Bleeding disorder				14) High Blood pressure		
3) Bone disease				15) Kidney or bladder problems		
4) Cancer				16) Liver Problems		
5) Chemical Dependency				17) Lung Problems (asthma, sleep apnea)		
6) Chronic Pain				18) Mental illness		
7) Depression				19) Skin Conditions/Psoriasis		
8) Diabetes				20) Stomach problems		
9) Disabled				21) Stroke		
10) Epilepsy or seizures				22) Ulcers		
11) Gout				23) Other		
12) Heart Disease						

PATIENT MEDICAL HISTORY

Are you (**patient**) currently or have you previously received treatment for the following?

CONDITION	YES	NO		CONDITION	YES	NO
1) Anxiety				14) High Blood pressure		
2) Arthrits				15) Kidney or bladder problems		
3) Asthma				16) Liver Problems		
4) Bleeding disorder				17) Lung Problems		
5) Cancer				18) MRSA		
6) Chemical Dependency				19) Rheumatoid Arthritis		
7) Cholesterol (high)				20) Skin Conditions/Psoriasis		
8) Chronic Pain				21) Sleep Apnea		
9) Diabetes				22) Stomach problems		
10) Epilepsy or seizures				23) Stroke		
11) Gout				24) Ulcers		
12) Heart Disease				25) VRE		
13) Hepatitis				26) Other		

SURGERIES

Have you ever had surgery or been hospitalized? Yes______ No______ If yes, please fill in the below:

OPERATION	ANESTHESIA (local or general)	DATE	ANY PROBLEMS?

Have you or anyone in your family had problems or reactions to anesthesia? ______________________________

List all your CURRENT MEDICATIONS: ____________________

____

____

What is your prefered pharmacy? ____________________

Are you receiving narcotic medication from any other physician? Yes_____ No_____

If yes, Physician name:____________________Medication:____________________

Are you allergic to Latex? Yes or No

Allergies (food & drug): Yes or No Reaction:

REVIEW OF SYSTEMS

Please check (x) the following symptoms that apply to you.

1. Cardiovascular	□ None	□ Painful breathing □ Palpitation □ Chest Pain □ Swelling of Legs □ Difficulty breathing on exertion □ Other ____________________
2. Constitutional	□ None	□ Fatigue □ Weight Gain □ Weight Loss □ Fever □ Other ____________________
3. Ear, Nose & Throat	□ None	□ Sore Throat □ Mouth Sores □ Sinusitis □ Hearing Loss □ Other ____________________
4. Endocrine	□ None	□ Diabetes □ Heat/Cold Intolerance □ Hypothyroid □ Hyperthyroid □ Hair Loss □ Hot Flashes □ Other ____________________
5. Gastrointestinal	□ None	□ Diarrhea □ Constipation □ Bloody Stool □ Pain □ Indigestion □ Nausea/Vomiting □ Other ____________________
6. Head & Eyes	□ None	□ Headache □ Vision Change □ Glasses/Contacts □ Other ____________________
7. Hematologic/ Lymphatic	□ None	□ Bruises □ Enlarged Lymph Nodes (Glands) □ Bleeding □ Other ____________________
8. Muscoskeletal	□ None	□ Muscle Weakness □ Muscle or Joint Pain □ Other ____________________
9. Neurologic	□ None	□ Severe Memory Problems □ Seizures □ Fainting □ Numbness □ Trouble Walking □ Other ____________________
10. Psychiatric	□ None	□ Depression □ Crying □ Severe Anxiety □ Other ____________________
11. Respiratory	□ None	□ Wheezing □ Cough □ Shortness of Breath □Spitting up Blood □ Other ____________________
12. Skin	□ None	□ Rash □ Dry Skin □ Sores □ Moles □ Other ____________________
13. Urinary	□ None	□ Blood in Urine □ Incomplete Emptying □ Painful Urination □ Frequency □ Urgency □ Incontinence □ Other ____________________

DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________________ **Date:** ____________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: 0—*Never or almost never* have the symptom 1—*Occasionally* have the symptom 2—*Frequently* have the symptom

I. Medical Symptoms Questionnaire (MSQ)

HEAD
- ____ Headaches
- ____ Faintness
- ____ Dizziness
- ____ Insomnia

TOTAL ____

EYES
- ____ Watery or itchy eyes
- ____ Swollen, reddened or sticky eyelids
- ____ Bags or dark circles under eyes
- ____ Blurred or tunnel vision

TOTAL ____

EARS
- ____ Itchy ears
- ____ Earaches, ear infections
- ____ Drainage from ear
- ____ Ringing in ears, hearing loss

TOTAL ____

NOSE
- ____ Stuffy nose
- ____ Sinus problems
- ____ Hay fever
- ____ Sneezing attacks
- ____ Excessive mucus formation

TOTAL ____

MOUTH/THROAT
- ____ Chronic coughing
- ____ Gagging, frequent need to clear throat
- ____ Sore throat, hoarseness, loss of voice
- ____ Swollen or discolored tongue, gums, lips
- ____ Canker sores

TOTAL ____

SKIN
- ____ Acne
- ____ Hives, rashes, dry skin
- ____ Hair loss
- ____ Flushing, hot flashes
- ____ Excessive sweating

TOTAL ____

HEART
- ____ Chest pain
- ____ Irregular or skipped heartbeat
- ____ Rapid or pounding heartbeat

TOTAL ____

LUNGS
- ____ Chest congestion
- ____ Asthma, bronchitis
- ____ Shortness of breath
- ____ Difficulty breathing

TOTAL ____

DIGESTIVE TRACT
- ____ Nausea, vomiting
- ____ Diarrhea
- ____ Constipation
- ____ Bloated feeling
- ____ Belching, passing gas
- ____ Heartburn
- ____ Intestinal/stomach pain

TOTAL ____

JOINTS/MUSCLE
- ____ Pain or aches in joints
- ____ Arthritis
- ____ Stiffness or limitation of movement
- ____ Feeling of weakness or tiredness
- ____ Pain or aches in muscles

TOTAL ____

WEIGHT
- ____ Binge eating/drinking
- ____ Craving certain foods
- ____ Excessive weight
- ____ Water retention
- ____ Underweight
- ____ Compulsive eating

TOTAL ____

ENERGY/ACTIVITY
- ____ Fatigue, sluggishness
- ____ Apathy, lethargy
- ____ Hyperactivity
- ____ Restlessness

TOTAL ____

MIND
- ____ Poor memory
- ____ Confusion, poor comprehension
- ____ Difficulty in making decisions
- ____ Stuttering or stammering
- ____ Slurred speech
- ____ Learning disabilities
- ____ Poor concentration
- ____ Poor physical coordination

TOTAL ____

EMOTIONS
- ____ Mood swings
- ____ Anxiety, fear, nervousness
- ____ Anger, irritability, aggressiveness
- ____ Depression
- ____ Slurred speech

TOTAL ____

OTHER
- ____ Frequent illness
- ____ Frequent or urgent urination
- ____ Genital itch or discharge

TOTAL ____

GRAND TOTAL TOTAL ____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean
"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of Disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid Herb, Homeopathic Remedy, water, dietary fat, dietary protein, or dietary carbohydrates.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herbs, Water, Dietary fat, Dietary protein, or dietary carbohydrates, may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

I have read and understand the above:

Signature ______________________ Date:__________

PATIENT OFFICE POLICY

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

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

Signing In
When you arrive, please sign in at the front desk (initials only please). You will be called and assigned a treatment room in the order that you signed in. Other patients may be called in before you because of the particular services being received that day. When you go to the assigned treatment room, place the folder in the door tray, rest, relax and he doctor will be in as soon as possible.

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

Appointments
After your visit, please stop at the front desk to make or confirm your next appointment. We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is necessary to obtain the best possible results we both desire. If you need to change a scheduled appointment, please reschedule your appointment for another time on the same day. If the same day is not possible, please be sure to make up the missed appointment within one week.

Missed appointments require a 24 hour notice. Missed appointments are subject to a cancellation fee which will be 35.00$ or higher depending on the charge of the services performed on the scheduled day. This is your responsibility and cannot be billed to your insurance company. Late arrivals need to note that precedence is given to patients who are on time for their scheduled appointment.

Progress Evaluations & Re-examinations
Progress evaluations &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.

______________________________ NAME

______________________ DATE

______________________________ SIGNATURE

FINANCIAL POLICY

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.
Payment for your first day services are due in full at the time they are rendered. This may include charges for examination, x-rays and treatment. We accept cash, checks, Master Card or Visa. Following your examination we will discuss your charges with you.
If you have insurance, we will verify your individual coverage by your second visit so long as you provide us with a copy of your insurance card which must have a policy or group number and a phone number for us to call for verification. Upon obtaining the insurance company address we will bill the insurance company for all charges.

PAYMENT POLICY:

You must realize, however, that:

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We will require payment upon each visit until your deductible is met. Once your deductible has been satisfied we will expect payment weekly of the percentage your insurance does not pay. This percentage usually ranges from 10% to 20%. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All co pays are due on the date of service. In case of deductibles and coinsurance, statements are sent out as soon as EOB's (Explanation of Benefits) are processed. Payments are due immediately. Our primary goal is health care and we endeavor to make the process of achieving optimum health as stress free as possible. If the patient experiences monetary constraint we do offer a payment plan of three consecutive payments which will be 30 days apart. The first payment is due immediately, the second is due 30 days later, and the third is due 30 days after that. If any payments are missed, interest of 21% will be charged on the entire amount and that balance will be due immediately.

We emphasize that as health care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask you to contact us immediately so we may assist in the management of your account.

I HAVE READ AND AGREE TO ABIDE BY THE ABOVE MENTIONED FINANCIAL POLICY AND FULLY UNDERSTAND ITS CONTENT.

____
NAME

____
DATE

____
SIGNATURE

PATIENT CONSENT FORM

Woods Chiropractic and Functional Medicine, P.S.C | 106 Browns Lane Louisville, KY 40207 | (502) 893-0757

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at ant time at the address below to obtain a current copy of the *Notice of Privacy Practices*:

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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME ______________________ DATE ______________

SIGNATURE ______________________