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

Patient Information

Date: _____

Name: _____ Age: _____ Preferred Name: _____

Date of birth: _____ Gender: _____

Marital Status: _____ Spouse/Partner name: _____

Number of Children: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (HOME): _____ (CELL): _____(WORK):_____

EMAIL ADDRESS: _____

How do you prefer to be reached? □ Home Phone □ Cell □ Work Phone □ Email address

Occupation: _____ Employer: _____

Who can we thank for referring you? _____

Primary Care Physician: _____ Phone#: _____
May we contact your PCP regarding your care? YES _____ NO _____

Guarantor (if different than patient)
Name: _____Relationship: _____Phone#: _____

Emergency Contact Name: _____ Phone#: _____

Who is responsible for your bill? □ You □ Spouse □ Health Insurance □ Auto Carrier

□ Medicare □ Workers Comp □ Other (Explain) _____

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Patient Name: _____ **Date:** _____

1. What is your chief complaint: _____

2. How would you describe the type of pain?

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

3. Who else have you seen for this problem?

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER Physician	□ Orthopedist	□ Massage Therapist
□ Physical Therapist	□ Other	□ No One

4. How long have you had this problem? _____

5. What is your: Height _____ Weight _____

6. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

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7. 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 previously and presently have a condition listed below, place a check in the "past and present" column. If you only presently have a condition listed below, place a check in the "present".

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

8. List all nutritional supplements you are currently taking:
_____

9. Have you ever been hospitalized? □ YES □ NO

If yes, please describe why and the date of hospitalization: _____

_____

10. Anything else pertinent to your visit today? _____

Name: Height: Weight: _____

Date: Average Blood Pressure: ----

1. List any medications that you are taking and the reason for it:

Medication	Reasons for taking medication

2. Do you like fish? Y/N If you answered yes, how often do you eat it per week/month? _____

   What kind of fish do you prefer to eat? _____

3. How often do you have meals outside your home per week?

4. Rate how mindful you are to include a green salad or fresh vegetables with each meal:
   Not at all 1 2 3 4 5 6 7 8 9 10 always

5. Do you like to exercise? Y / N what do you do and how often?
   _____
   _____

6. Do you stretch in the morning or evening? Y / N Engage in Yoga? Y / N

7. How is your sweet tooth?
   Under control 1 2 3 4 5 6 7 8 9 10 It's a monster

8. Do you or have you ever smoked tobacco? Y / N

9. How many glasses of beer, wine or mixed drinks per week? _____

10. Do you consume organic fruits and vegetables in your home? If yes... please specify:
    _____
    _____

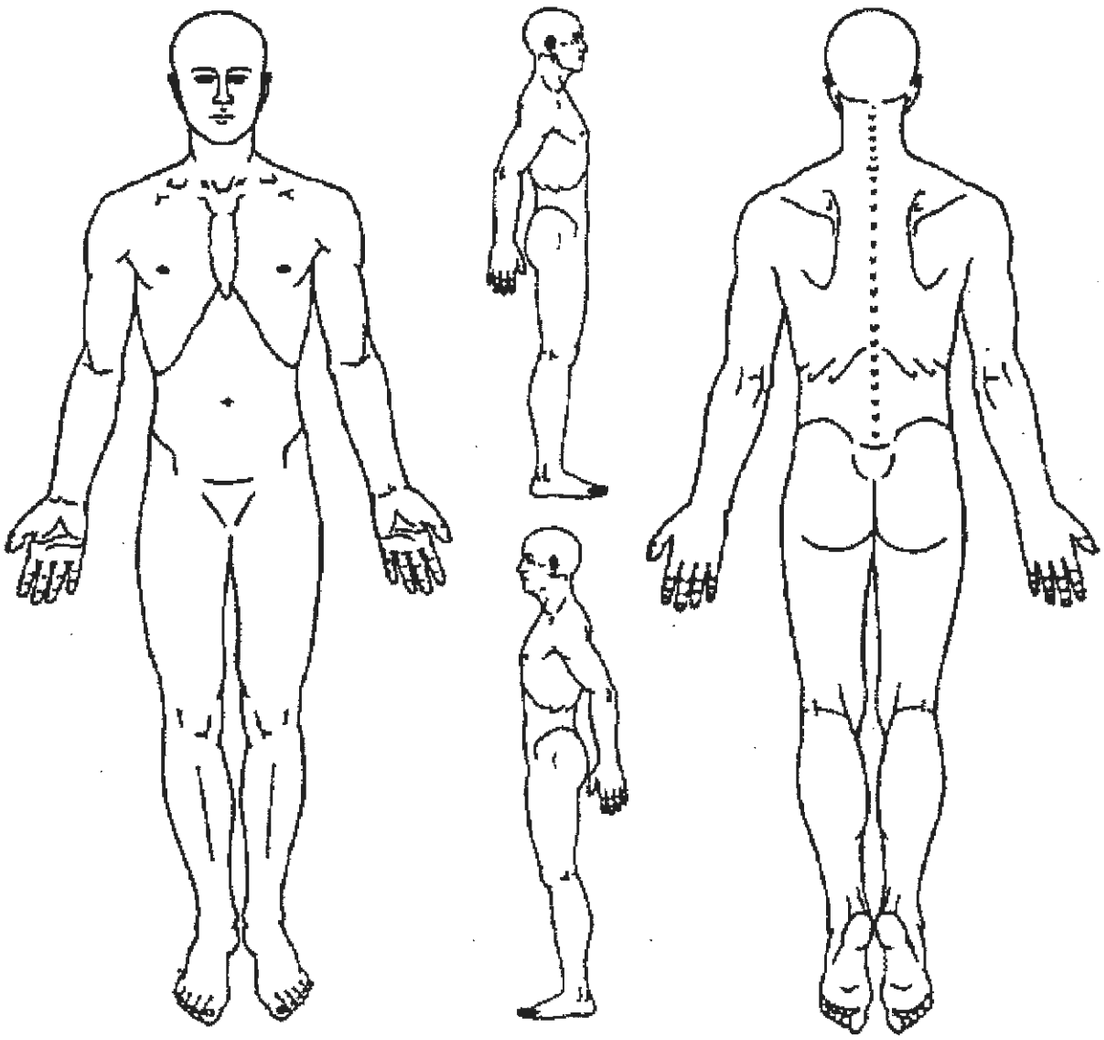
11. Do you have an interest in holistic health and learning on how to take care of your body?
    Yes I am here for you to help me 1 2 3 4 5 6 7 8 9 10 I take interest in articles or go online to learn.

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

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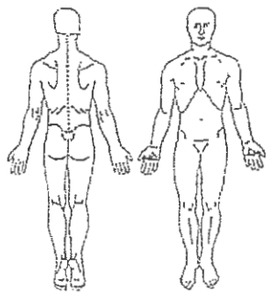
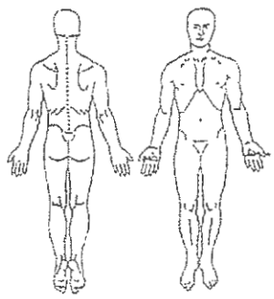
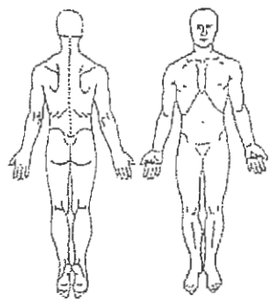
NAME **DATE**

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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Patient Name: _____ **Date:** _____

Treatment Authorization

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and I. 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 $25.00 fee if I do not change or cancel my scheduled appointments with at least a 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 for third party payers.

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

_____

Patient

_____

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
- □ Communication barriers prohibited obtaining the Acknowledgment
- □ An emergency situation prevented us from obtaining Acknowledgment
- □ Other (Please Specify)

Staff Signature Date
