American Wellness Center

Patient Name: _____ **Date:** _____

Address_____APT#_____

City_____ State _____ Zip Code _____

Home Phone _____ Work Phone_____

Cell Phone _____ Cell Carrier (if you would like to receive text reminders) _____

Email Address: _____ How would like to be reminded of appointments? ☐ E-mail ☐ Text

Sex: M F Date of Birth_____ Age_____ Social Security #_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other ____

Ethnicity ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino **Language** ☐ English ☐ Spanish ☐ Other

Occupation_____ Employer_____

Referred by: _____ Height: _____Weight _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Primary Care Physician:_____Phone Number:_____

1. **Reasons for seeking care:** Is this visit due to an accident? ☐ Yes ☐ No If so, ☐ Auto ☐ Work ☐ Other

Primary reason: _____

Secondary reason: _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

3. **Past Health History:**
   Please indicate if you have a history of any of the following:
   A. **All Surgeries:** _____
   _____
   B. **Previous Injury or Trauma:** _____
   _____
   C. **Have you ever broken any bones? Which?** _____
   _____
   D. **Allergies:** _____
   _____
   E. **Medications:** **Reason for taking:**
   _____
   _____

Patient Name: _____ Date: _____

F. Females/ Pregnancies and outcomes:

Our consultation and examination may indicate the x-rays are necessary to accurately diagnose and analyze your conditions. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

□ There is a possibility that I may be pregnant at this time*

□ Yes, I am definitely pregnant

□ No, I am definitely not pregnant at this time

Date of last menstrual period:_____

*If there may be a possibility that you are pregnant, we would like to perform a urine pregnancy test prior to performing an x-ray to prevent any harm to your fetus.

Pregnancies/Date of Delivery Outcome

_____ _____

_____

_____ _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or sibling's death Age at death

_____

_____

Social and Occupational History:

A. **Job description:** _____
B. **Work schedule:** _____
C. **Recreational activities:** _____
D. **Are you are current or former smoker?** _____
   If yes: How many packs do you smoke in a day? _____
E. **Do you have a history of drug abuse/addiction?** _____
F. **Do you consume alcoholic beverages? If yes how much in a week?** _____

_____

8417 E. McDowell Road
Scottsdale, Arizona 85257

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Fax 480-946-2559

Patient Name: _____ **Date:** _____

Review of Systems

PLEASE MARK ALL THAT APPLY

1. Have you had any of the following pulmonary (lung-related) issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Chest congestion □ Wheezing □ Frequent sneezing
□ Chronic cough □ Coughing Blood □ Sleep Apnea □ Other _____ □ None of the above

2. Have you had any of the following cardiovascular (heart-related) issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ High Blood Pressure
□ Heart disease/problems □ Defibrillator □ High Cholesterol □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

3. Have you had any of the following neurological (nerve-related) issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ Slurring of speech
□ One-sided decreased feeling in the face or body □ Headaches □ Migraines □ Memory loss □ Hearing loss □ Tremors
□ Vertigo □ Loss of sense of taste/smell □ Strokes/TIAs □ Multiple Sclerosis □ Other _____ □ None of the above

4. Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Fatigue □ Weight Loss □ Weight Gain □ Low Blood Sugar
□ Diabetes □ Other _____ □ None of the above

5. Have you had any of the following Genitourinary (kidney-genitals) issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in urine) □ Incontinence □ Bladder Infections □ Difficulty urinating
□ Urinary Urgency □ Prostate Disease □ Prostate Cancer □ Kidney disease □ Dialysis □ Sexually Transmitted
Disease □ Other _____ □ None of the above

6. Have you had any of the following gastroenterological (stomach-related) issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Chron's Disease □ Diverticulitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Irritable Bowel Syndrome □ Gastroesophageal reflux/heartburn
□ None of the above □ Other _____

7. Have you had any of the following hematological (blood-related) issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia/Clotting Disorder
□ Blood Clots/Deep Vein Thrombosis □ Anticoagulant therapy □ Regular aspirin use □ Other _____
□ None of the above

8. Have you had any of the following dermatological (skin-related) issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Bruise easily? □ Brittle nails?
□ Skin Cancer □ Hair Loss □ Other _____ □ None of the above

9. Have you had any of the following musculoskeletal (bone/muscle-related) issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint
surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Fibromyalgia □ Lyme Disease □ Other_____
□ None of the above

10. Have you had any of the following psychological issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Anxiety □ ADD/ADHD □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to this office for services performed.

Patient or Guardian Signature _____ Date_____

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Patient Name: _____ **Date:** _____

PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
  -

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
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Patient Name: _____ **Date:** _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The practitioner, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the practitioner. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Signature of Patient/Guardian Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____ _____

Signature of Patient/Guardian Date

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Fax 480-946-2559

Patient Name: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of American Physical Medicine, American Physical Therapy, and/or American Chiropractic Center. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine email address, text message, or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

NOTICE TO PATIENTS

A physician must notify a patient that the physician has financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, whether such treatment, goods or services are available elsewhere on a competitive basis. R4-7-902.1. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are hereby advised that Vincent Amoia, D.C. and Lynn Genet, D.C. have a direct financial interest in American Physical Therapy Inc., American Physical Medicine, Inc. and American Medical Center, PC. Further, the physical medicine services we have prescribed are available elsewhere on a competitive basis.

We ask that you acknowledge your having read and understood the disclosure contained in this notice by signing and dating this form in the spaces provided below. We will keep the signed original in your patient file.

ACKNOWLEDGEMENT: I have read this "Notice to Patients" form, and I understand the disclosures that it contains.

_____ _____
Signature of Patient/Guardian Date

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Scottsdale, Arizona 85257

Phone 480-946-3399
Fax 480-946-2559

Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

8417 E. McDowell Road
Scottsdale, Arizona 85257

Phone 480-946-3399
Fax 480-946-2559

DIAGNOSTIC X-RAY CONSULTATION SERVICES®

GARY A. LONGMUIR, M.App.Sc., D.C., Ph.D., D.A.C.B.R.
Radiology

Diplomate, American Chiropractic Board of Radiology
Fellow, the American Chiropractic College of Radiology

29479 N 120th Lane
Peoria, AZ 85383-2407
Telephone: (602) 274-3331
Fax: (602) 279-4445
www.diagnosticx-ray.com

PATIENT AUTHORIZATION

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I authorize the release of my medical information necessary to assist in my care at my physician's office.

Date_____ **Patient's Signature** _____
(Parent or guardian if minor child)

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.