

American Wellness Center

Patient Update

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: _____

4. 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

Pregnancies/Date of Delivery	Outcome

5. 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 siblings death

Age at death

Cause of parents or siblings 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? _____

Patient Name: _____

Date: _____

Review of Systems

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 Tremors Vertigo
 Loss of sense of smell/smell Strokes/TIAs Multiple Sclerosis Hearing Loss 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 the urine) Incontinence (can't control) 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 _____

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):
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- 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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Date: _____

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):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
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GARY A. LONGMUIR, M.App.Sc., D.C., Ph.D., D.A.C.B.R.

Radiology

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Fellow, the American Chiropractic College of Radiology*

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www.diagnostics-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.

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