



Patient Information

Name:		Today's Date:	
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Email Address:	Race:	Ethnicity (Check One): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Employer:	Occupation:		
Work Address:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Birth Date:	
Patient SS#:			
Spouse Name:	Children Names/Ages:		
Insured Date Of Birth:			
Would You Like to Receive Appointment Reminders? (Check one or both) <input type="checkbox"/> Text Message on your Mobile Phone <input type="checkbox"/> Email			
Mobile Phone Carrier (to receive appointment reminders via text message) Circle One: Alltel AT&T Cellular One Nextel Qwest Sprint T-Mobile Verizon Virgin Mobile US Cellular Other: _____			
Whom may we thank for referring you?			

Patient Condition

Reason for visit:	
Desired Service: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage <input type="checkbox"/> Nutrition	
When did symptoms first appear?	
Is the condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Does it interfere with your: <input type="checkbox"/> work <input type="checkbox"/> sleep <input type="checkbox"/> daily routines <input type="checkbox"/> recreation	
Activities which are painful: <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> lying down <input type="checkbox"/> walking <input type="checkbox"/> bending	
Using the appropriate symbol, mark on the picture where you continue to have: Pain (X), Numbness (/), or Tingling (#)	
How would you describe your pain? Mark all that apply:	
<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Stiffness <input type="checkbox"/> Cramping <input type="checkbox"/> Other	
Is the pain: <input type="checkbox"/> Constant <input type="checkbox"/> Come and Go	
Have you had similar pain in the past and when?	

Quadruple Visual Analogue Scale

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

1. What is your pain RIGHT NOW?

no pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ worst possible pain

2. What is your TYPICAL or AVERAGE pain?

no pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ worst possible pain

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ worst possible pain

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain _____ 0 1 2 3 4 5 6 7 8 9 10 _____ worst possible pain

What percentage of your awake hours is your pain at its worst? _____%

Patient Goals/Expectations

Please tell us what your goals/expectations of your care are (check all that apply)-

- relief care – primary goal is to relieve your symptoms
- corrective care – complete the correction begun in the relief care
- stabilization – stabilize structures supporting the spine to prevent future episodes
- wellness – promotion of optimal functioning of all bodily systems
- other: _____

Family History

Place a "√" to indicate any immediate family members whom have a history of any of the following conditions.					
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Digestive Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Disease (Glaucoma, Macular Degen.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health History

Check treatments received for this condition? <input type="checkbox"/> Chiropractic <input type="checkbox"/> Medication <input type="checkbox"/> None <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Surgery					
Name and location of other Doctor(s) treating you for this condition:					
May we contact this physician?			Are you PREGNANT? <input type="checkbox"/> Yes (Due Date:) <input type="checkbox"/> No <input type="checkbox"/> Maybe		
Date of last: X-ray		MRI		CT-Scan	
Date of last: X-ray		MRI		Bone Scan	
Blood/Urine Test Other (Specify):					
Place a "√" to indicate if you currently have or have had any of the following:					
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No		High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia / Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety Attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		PMS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Celiac Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Prostate Problems (Men)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Sleep Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestion Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye/ Vision Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Tumor/Growth (non-cancer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
EXERCISE		WORK ACTIVITY		HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Mostly Sitting	<input type="checkbox"/> Mostly Standing	<input type="checkbox"/> Smoking: Packs/Day ()	
<input type="checkbox"/> Daily	<input type="checkbox"/> Heavy	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Alcohol: Drinks/Week ()	
Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, quit date:				<input type="checkbox"/> Coffee/Pop #/Day ()	
Please describe any of your SURGERIES or BROKEN BONES-Give Dates.					
SURGERIES:					
BROKEN BONES:					
Any other conditions not covered on this form?					
MEDICATIONS		ALLERGIES		VITAMINS/HERBS	
Medication	Frequency	Method	(Including Medications)		

Paun Family Chiropractic and Wellness, PC

Consent Form

Please read each section and sign below, even if you are not receiving chiropractic care.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease.

The most common therapeutic procedure performed by doctors of chiropractic is known as "spinal manipulation," also called "chiropractic adjustment." The purpose of manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile – or restricted in their proper movement – as a result of a tissue injury. Tissue injury can be caused by a single traumatic event, such as improper lifting of a heavy object, or through repetitive stresses, such as sitting in an awkward position with poor spinal posture for an extended period of time. In either case, injured tissues undergo physical and chemical changes that can cause inflammation, pain, and diminished function for the sufferer. Manipulation, or adjustment of the affected joint (as well as the use of other modalities) and tissues restores mobility, thereby alleviated pain and muscle tightness, and allowing tissue to heal.

The material risks inherent in Chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the timing of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

Assignment of Benefits – Financial Responsibility

I hereby request that payment of authorized Medicare and all other third party insurance/payor benefits be made directly to Paun Family Chiropractic and Wellness, PC (PFCW) for any services furnished to me by that supplier. I hereby assign payment for services provided to me by PFCW are made directly to PFCW. I understand that I am financially responsible for any co- payments, deductibles and non-covered services. PFCW accepts assignment on all Medicare/pay or covered services/supplies unless otherwise notified. I further acknowledge that any benefits paid directly to the beneficiary for services provided by PFCW will be endorsed and delivered/mailed to PFCW within 10 days of receipt.

If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort by this office. If this option must be used, a 20% fee will be added to your account to help with the fees incurred by this office. We will always work with you to get your account paid in full. If collections procedures fail to produce payment on your account, further action will be pursued in Small Claims Court, and any court and/or attorneys fees will be your responsibility. Any returned checks will be assessed a fee of \$25.70 or 5% of the check amount, whichever is greater, in accordance with State of Indiana regulations. If payment arrangements are not established with our office within a reasonable amount of time (within 12 days of notice sent by our office), further action will be pursued through the Prosecutors' Office to recoup our costs.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby authorize the Doctor to examine, perform diagnostic studies 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 Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I understand that my signature requests that payment by my insurance carrier be made directly to PFCW and that I am responsible for co-payments, deductibles and non-covered services.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

I have read and fully understand the above statements.

Patients/Guardians Signature: _____

(Date) _____

Paun Family Chiropractic and Wellness, PC

Privacy Notice

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Paun Family Chiropractic and Wellness, PC will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Paun Family Chiropractic and Wellness, PC to provide treatment to me, and also necessary for Paun Family Chiropractic and Wellness, PC to obtain payment for that treatment and to carry out its health care operations. Paun Family Chiropractic and Wellness, PC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.

2. Paun Family Chiropractic and Wellness, PC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by Paun Family Chiropractic and Wellness, PC:

- a.) a postcard mailed to me at the address provided by me; and
- b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.

4. Paun Family Chiropractic and Wellness, PC may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Paun Family Chiropractic and Wellness, PC to conduct its specific health care operations.

5. I understand that I have a right to request that Paun Family Chiropractic and Wellness, PC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Paun Family Chiropractic and Wellness, PC is not required to agree to any restrictions that I have requested. If Paun Family Chiropractic and Wellness, PC agrees to a requested restriction, then the restriction is binding on Paun Family Chiropractic and Wellness, PC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Paun Family Chiropractic and Wellness, PC has already taken action in reliance on this consent.

7. I understand that if I revoke this Consent at any time, Paun Family Chiropractic and Wellness, PC has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, the Paun Family Chiropractic and Wellness, PC will not treat me.

AUTHORIZATION FOR RELEASE OF RECORDS

Paun Family Chiropractic and Wellness, PC is authorized to disclose to my attorney, or his / her agent, as well as to any insurance carrier who may be liable for payment of bills and charges for services rendered to me, any information which may be acquired by examination, or other means, of my physical and mental condition; and I hereby release Paun Family Chiropractic and Wellness, PC of any consequences thereof.

Due to Federal and State Laws we are required to safeguard your medical information including any diagnostic films (X-rays, MRI, etc). We will send any films to the physician you requested via certified mail and you will be responsible for the postage at the time of the request.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Date Signed: ____/____/____

Signature of Individual Name of Individual (Printed)

Signature of Legal Guardian/if a minor Relationship

Paun Family Chiropractic and Wellness, PC **Cancellation Policy**

At Paun Family Chiropractic and Wellness, PC we have extended hours to accommodate our patients and their increased demands of life.

In return we request that we be notified within a 24 hour period if a cancellation is needed. This allows us the opportunity to properly schedule other patients in need of our services and to efficiently work around our own schedules.

A \$25 dollar fee will be automatically charged to your credit card on file if this policy is abused. Please note that we will take unforeseen circumstances into consideration and that this is mostly in effect for people who have a tendency to disregard our schedule.

If you have any questions, comments or concerns please feel comfortable to speak with Dr. Paun to avoid any miscommunication.

We appreciate your cooperation with this matter.

Signature: _____

Date: _____

Additional (Optional) Questions:

Would you be interested in a clinically supervised weight loss program if Paun Wellness were to offer it?

Yes Maybe NO

Would you like to be contacted about this in the future?

Yes Maybe NO

Would you be interested in professional quality supplementation if Paun Wellness were to offer it?

Yes Maybe NO

Would you like to be contacted about this in the future?

Yes Maybe NO

Would you be interested in a monthly massage and/or chiropractic adjustment program if Paun Wellness were to offer it?

Yes Maybe NO

Would you like to be contacted about this in the future?

Yes Maybe NO