HEALTHY SOLUTIONS CHIROPRACTIC WELLNESS CENTER
524 Morgantown Road, Suite E
Uniontown, PA 15401
(724) 434-2225

PATIENT INFORMATION

First Name:_____ Last Name:_____ M.I.:_____

Date of Birth:___/___/ _____ Age: ____ SS#:_____-____-_____ Gender: ___M ___F

Address: _____ Apt. #_____

City:_____ State:_____ Zip Code:_____

Phone: (home) _____ (work) _____ (cell) _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____

Marital Status: ____Single ____Married ____Divorced ____Separated ____Widowed

Spouse's Name: _____ Number of Children: _____

Spouse's Occupation: _____ Spouse's Work Phone: _____

Primary Care Physician: _____ Phone: _____

Who should we contact in the case of an emergency? _____

Phone: _____ Relationship to patient: _____

Who referred you to this office? _____

Why are you seeking care at this office? _____

_____

Other doctors seen for this problem, if any: _____

Is this condition related to a: _____Work injury ____Auto accident _____Neither

Signature of Patient:_____ Date: _____

Printed Name of Legal Guardian (if applicable): _____

Signature of Legal Guardian: _____ Date: _____

HEALTH / MEDICAL HISTORY

Patient: _____ Date: _____

Please list any previous chiropractic care:

Doctor: _____ When: _____

Doctor: _____ When: _____

Please list any medications you are currently taking:

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Please list all past surgeries:

Procedure: _____ When: _____

Procedure: _____ When: _____

Procedure: _____ When: _____

Please list any past injuries, falls, auto accidents, broken bones:

What: _____ When: _____

What: _____ When: _____

What: _____ When: _____

What: _____ When: _____

What: _____ When: _____

What: _____ When: _____

Please list (if applicable): Number of pregnancies _____; Number of children _____

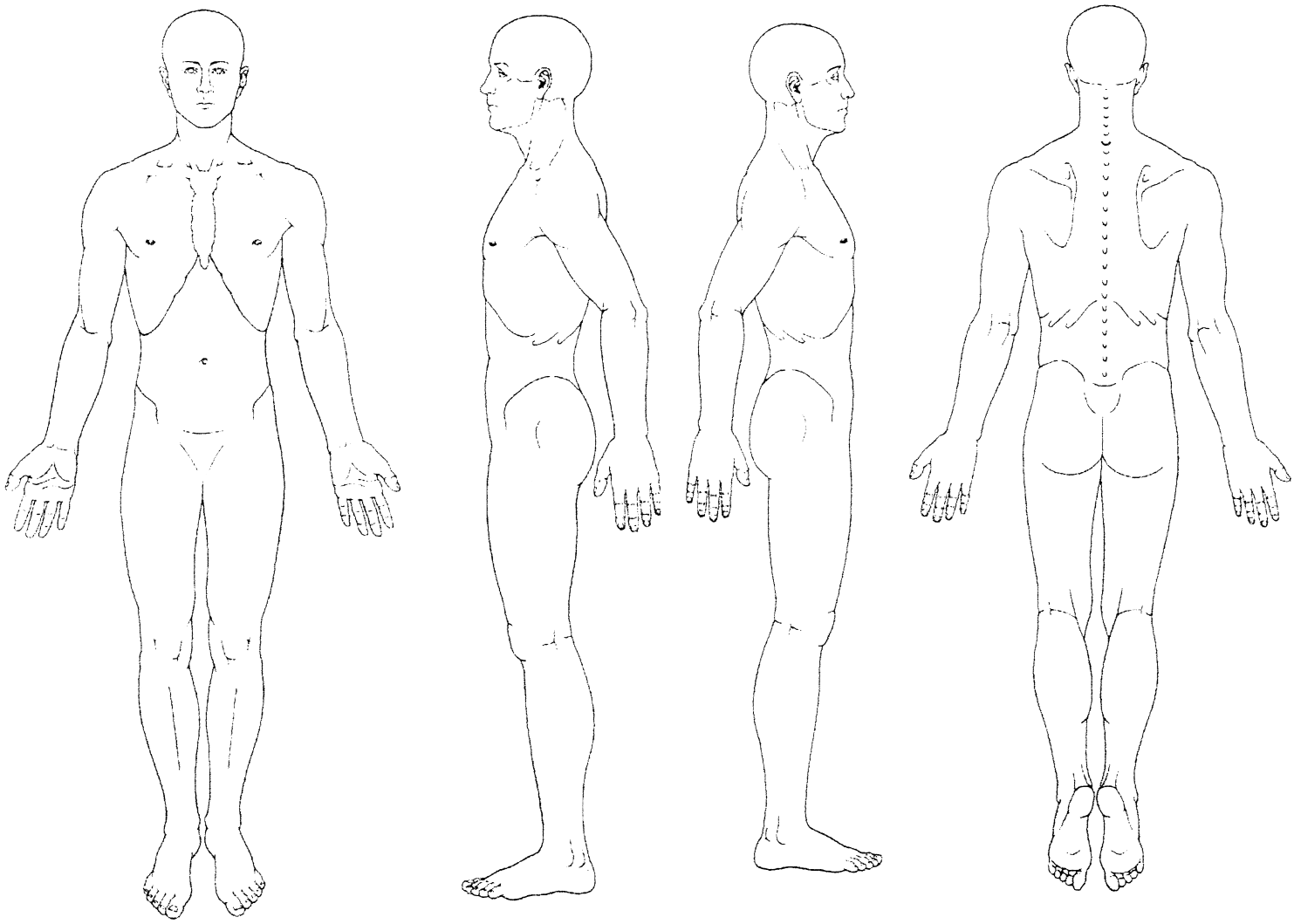
Family Medical History (circle all that apply):

Father:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____
Mother:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____
Brother:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____
Sister:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____
Father's Side:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____
Mother's Side:	Arthritis	Cancer	Diabetes	Heart Disease	Other: _____

Patient Signature: _____ Date: _____

PAIN LOCATION

Patient: _____ Date: _____



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

Patient Signature: _____ Date: _____

Consent For Treatment

I hereby request and authorize Dr. William Moffatt to perform chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below for whom I am legally responsible). This authorization also extends to all other doctors and staff members of Healthy Solutions Chiropractic Wellness Center.

I have had an opportunity to discuss with Dr. Moffatt and/or authorized members of the office staff the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprain/strains. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I (or the patient named below) seek treatment.

(If applicable regarding a minor patient) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____
(Printed Name of Patient)

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Printed Name of Legal Guardian, if applicable) (Relationship to Patient)

_____ _____
(Signature of Witness) (Date)

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

(Printed Name) (Authorized Provider Representative) (Date)

_____

(Signature) (Date)

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

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

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____	_____
(Patient Name Printed)	(Personal Representative Printed)	(Authorized Provider Representative)
_____	_____	_____
(Patient Signature)	(Personal Representative Signature)	(Date)
_____	_____	
(Date)	(Date)	

Description of Personal Representative's authority to act for the patient: _____

_____

_____

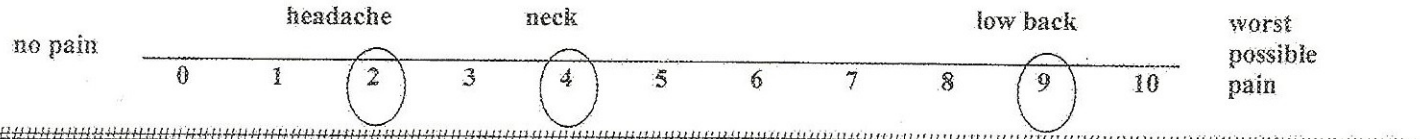
_____

Healthy Solutions Chiropractic Wellness Center, PC
524 Morgantown Road, Uniontown, PA 15401
724-434-2225

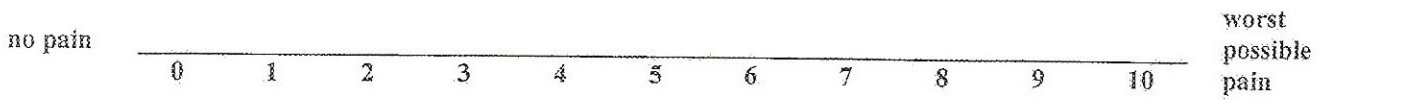
QUADRUPLE VISUAL ANALOGUE SCALE

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.

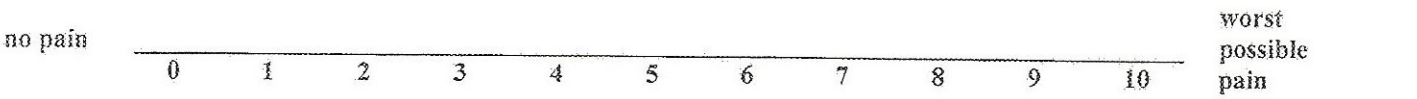
EXAMPLE:



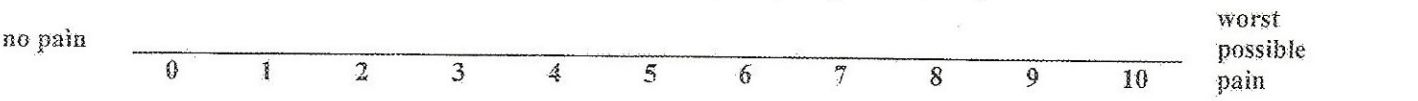
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

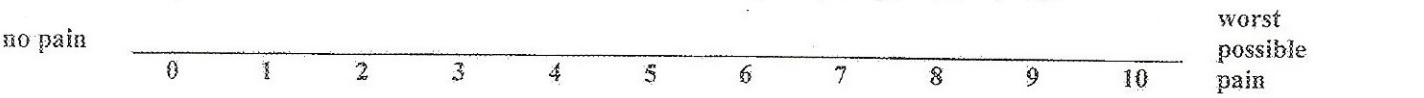


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



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)?



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

NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)