Infinite Wellness, Inc.
Confidential Patient Information Form

Today's Date ____________________
Name ___________________________________ Date of Birth _____/_____/_______ Age__________
Address ____________________________________City ____________________ Zip ____________
Home Phone ( ) _____________________ Cell Phone ( ) _______________________
Email Address ____
Marital Status: Married Single Widowed Divorced Sex: Female/Male Children Y / N # _____

Occupation _________________________________Employer ________________________________
Address ____________________________________City ________________Zip _________________
Emergency contact __________________________ Contact Phone ____________________________
Relationship of emergency contact: (Parent Spouse Other Relative Friend)

Referred By (circle): Internet - Website / Ins. – PPO Directory / Other physician / Friend - Relative
Name ____
Reason for your visit today? ____
Have you seen other doctors / chiropractors for this problem? Y / N If yes, who __________________

Is your visit the result of an auto or work injury? Y / N If yes, which ________________________
If your visit is related to either of these we will need a workers compensation form from your employer, or an accident report And insurance information from the other driver of the vehicle you were in an accident with. If you have spoken with an Attorney then we will need the contact information of your attorney.
Name of attorney: ____________________________ Law FirmTitle:___________________________

PAYMENT / INSURANCE INFORMATION

Are you insured? Y / N (*If yes we will need a copy of your card*) Carrier Name: _______________________
Are you the insured person or dependent? ***(Self Wife Husband Child)***
Name of Insured:___________________________________ Insured persons DOB: ____/____/______.
Insured's Address:____.

Copay amount per visit? $__________ Percentage:________/________%

Do you have a deductible? If so amount: $_______________. Have you met it for this year? Y / N

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAY FOR REGULAR INSURANCE PATIENTS.

Infinite Wellness, Inc. will provide insurance billing services for you if you desire as a courtesy.
Remember that you are ultimately responsible for any charges incurred in our office. It is your responsibility to pay any deductible amount, insurance co-pay, and or any other balances not paid by your insurance carrier. With your signature you agree to pay for any outstanding bills incurred in our office and hereby state that all of the above information is truthful and accurate to the best of your knowledge.

Signature of responsible party (Patient or Parent): ________________________ Date:__________________

Infinite Wellness, Inc.
Past and Present Health History Form

Name ____ **Today's Date** ____________________

	Current Conditions		**Past Conditions**	**Year**
☐	I have frequent headaches / migraines	☐	I have a history of heart attacks	
☐	I bruise easily / I heal slowly	☐	I have had a stroke	
☐	I have a thyroid / adrenal disorder	☐	I have a history of gout / psoriasis	
☐	I have rheumatoid arthritis	☐	I have scoliosis / spondylolesthesis	
☐	I have been told I have osteoarthritis	☐	I have had Spinal Surgery	
☐	I have been told I have osteoporosis	☐	I have had other joint surgeries	
☐	I have seizures	☐	I had seizures in the past (last)	
☐	I have and am being treated for cancer	☐	I have had cancer	
☐	I currently am a smoker	☐	I used to smoke	
☐	I am a diabetic	☐	I was in an auto / work accident	
☐	I am on medications for vascular problems	☐	I have had breast implant surgery	
☐	I am currently Pregnant	☐	I have had C-section deliveries	

Broken Bones / Surgical Procedures – please list area and year

☐ **I have never had any broken bones** ☐ **I have never had any surgical procedures**

Region	Year	Region	Year

Please Check Your Current Symptoms

☐ **I am only here for wellness care**

☐ **Headaches/ Migraines** ☐ **Neck Pain/Stiffness** ☐ **Midback Pain/Stiffness** ☐ **Low Back Pain/Stiffness**
☐ **Hip Pain** ☐ **Shoulder Pain/ Stiffness** ☐ **Knee Pain** ☐ **Elbow Pain** ☐ **Ankle/Foot Pain**
☐ **Wrist/Hand Pain** ☐ **Numbness/Tingling (location)**_______________ ☐ **Muscle Spasms/Pain**
☐ **OTHER: (please describe)** ____
Of these, which symptom is your **primary concern?** ____

Symptom / Pain Description:

(Please circle all that apply)

Ache	Cutting	Pulling	Annoying	Stiff	Tingling	Burning	Numbness	Shooting
Soreness	Stabbing	Spreading	Deep pain	Sharp	Throbbing	Stinging	Radiating	Weaknes

Have you ever seen a Chiropractor for this or any other condition? Y / N If yes: Year seen:___________
Clinic Name:__________________________ Problem seen for:____

Current Medications you are Taking

☐ **I am not taking ANY medications**

☐ Muscle Relaxers	☐ Zoloft / Paxil / Effexor	☐ Lisinopril	☐ Gabapentin	☐ Allegra
☐ Narcotics for pain	☐ Prozac / Welbutrin	☐ Tramadol	☐ Celebrex	☐ Lunesta
☐ Heart Medication	☐ Lyrica	☐ Hydro/Oxycodone	☐ Lortab	☐ Insulin
☐ Aspirin / Tylenol / Advil	☐ Lipitor	☐ Vicodin / Percocet	☐ Zyrtec	☐ Singulair
☐ Other Anti-Inflammatories	☐ Metformin	☐ Prednisone	☐ Coumadin	☐ Ritalin
☐ Synthroid / Levothyroxine	☐ Cymbalta	☐ Ambien	☐ Prilosec	☐ Birth Control

☐ **Other (please specify)** ____

Signature of responsible party (Patient or Parent): ___________________________________

Consent to Chiropractic Examination and Care

I hereby authorize Infinite Wellness, Inc. and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.
The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.
By signing below I acknowledge my consent to be examined:

____
Patient's Printed Name

____ **Date:_____/_____/_________**
Patient's Signature

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.
To aid the understanding of my condition and the reasons for the proposed course of care, the Practice has provided me with specific pamphlets and other literature (and videos) and Practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I understand and accept that:

1. **I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.**
2. **That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.**
3. **That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.**
4. **The Practice does not guarantee as to results with respect any course of care or treatment.**
5. **My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.**

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Physicians of Infinite Wellness, Inc.

____
Patient's Printed Name

____ **Date: _____/_____/_________**
Patient's Signature

____ **Date: _____/_____/_________**
Signature of doctor