FAULKNER
CHIROPRACTIC & WELLNESS

Welcome to our office!

To ensure your **first visit** is a pleasant one, here are the Procedures you can expect during the next 30 minutes with us:

Paperwork Complete this brief questionnaire to help us get to know you. The doctor will use this information to help formulate the recommendations for your care

Consultation You'll meet the doctor who will review your health history and determine if yours is a chiropractic case.

Examination Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your condition.

X-Ray Exam Necessary views may be taken to visualize the location of any spinal problems, reveal any pathology, and make your chiropractic care more precise.

Correlation Before proper care can be rendered the doctor will study your all of your examination findings.

Adjunctive Procedures The doctor may suggest the application of ice, heat, or the use of other modalities to help reduce pain and inflammation and make you more comfortable.

Next Visit Your first visit is complete. Plan to spend about 30 minutes on your next visit. The Doctor will give you an in-depth report of findings for your particular condition.

At your **second visit** the doctor will explain the result of your examinations and offer choices for appropriate chiropractic care. Here's what to expect:

Patient Education The doctor will help you understand your x-rays, the doctor's report of findings, and recommendations for chiropractic care.

Report of Findings You'll see your x-rays and receive a complete report of the examination findings from the doctor.

Treatment Plan The doctor will outline a treatment plan designed for your unique spinal problem and health complaint.

Questions Ask questions at anytime. Make sure you fully understand the nature and severity of your condition and what we are doing to help you.

Expectations Based on clinical experience, the doctor will explain to you prospects for recovery and what you can do to help speed the healing process.

Financial Issues So we can direct all of our attention to your recovery, the financial responsibility for your case will be discussed.

Adjustments The doctor will use carefully directed and controlled pressure to restore the movable bones of your spine to a more normal motion and position. Our patients enjoy their "adjustments" and often report the beginning feelings of relief and well-being.

The Future Your second visit is complete. Future visits will be of a more typical length, usually about 15 to 20 minutes.

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ABOUT YOU

1

FAULKNER
CHIROPRACTIC & WELLNESS

Today's Date: _____/______/______ File #: ____________________

Patient Name: ____
Last First MI

What would you prefer to be called: _______________ ☐ Male ☐ Female

Birth Date: ____/_____/_____ Age: ______ SS#: _________________

Mailing Address: ____

____
City State Zip

Home Phone #: ____

Work Phone #: ______________________________Ext:____________

Other Phone #: ____

E-Mail Address: ____

Referred By: ____

Employer: _____________________________ How Long? _________

Employer's Address:____

____
City State Zip

Occupation: ____

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

Spouse's Name: ____

Do you have children? ☐ Yes ☐ No How many? ______________

WELCOME

INSURANCE INFO

2

Co Name: ____________________________________

Address: _____________________________________

____
City State Zip

Phone#: ______________________________________

Insured's SS#: _________________________________

Insured's Name: ______________________________

Relation: ___________Date of Birth: ___/_____/______

Insured's Employer:___________________________

Please inform front desk of 2nd Insurance source.

REASON FOR VISIT

3

The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.

(Explain what happened): ____

____

Please describe the pain & its location: ____

____

When did the condition begin? ____/____/____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

Is this condition interfering with your (Please circle): work, sleep, or daily routine.

If so, please explain:____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain:____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? ____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom?__________________________________ Phone #________________________

4

IN EVENT OF AN EMERGENCY

Who should we contact? ______________________________

Relation:______________________________

Home Phone #: ________________ Work Phone #: ________________

Who is your Medical Doctor? ________________ Phone #: ________________

HEALTH HISTORY

5

Are you taking any of the following medications?

□ Nerve Pills □ Pain Killers (including aspirin) □ Muscle Relaxers □ Stimulants
□ Blood Thinners □ Tranquilizers □ Insulin □ Other (s) __________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y N** Heart Surg/Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+/AIDS	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema/Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headache	**Y N** Kidney Problems	**Y N** Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes/Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Pain	**Y N** Artificial Bones/Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything you may be allergic to: ______________________________

____

List previous surgeries/treatments with dates: ______________________________

____

List any **past** serious accidents with dates: ______________________________

____

Family Health History: ______________________________

____

Do you: Take Supplements or Vitamins? □ Yes □ No Exercise? □ Yes □ No
Are you on a special diet: □ Yes □ No Since: ____/____/______
Do you smoke? □ Yes □ No How Much? _________ How Long? ____________
Are you wearing: □ Heal Lifts □ Sole Lifts □ Inner soles □ Arch Supports
What is the age of your mattress? ___________ Is it comfortable? □ Yes □ No
For Women: Are you taking Birth Control? □ Yes □ No
Are you pregnant? □ No □ Yes How long?_____ Nursing? □ Yes □ No

6

ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____
City State Zip

SSN#:______________________________

DL#:______________________________

Work Phone: ______________________________

Payment Method: □ Cash □ Check

______________________________exp _______/________
□ Credit Card – Enter card # above (if applicable)

_____ I hereby authorize assignment of my insurance rights and my
Initial insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- ❑ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient.
- ❑ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.
- ❑ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or management care organization, to release any information required to process insurance claims.
- ❑ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature______________________________ Date _____/_____/__________
□ Adult Patient □ Patent or Guardian □ Spouse

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PAIN CHART

ABOUT YOU

Name: ____ ____ File #: ___________________________

What is your current weight: ___________lbs., and height, _____Ft. ______In._________

Please describe you condition: ____

____

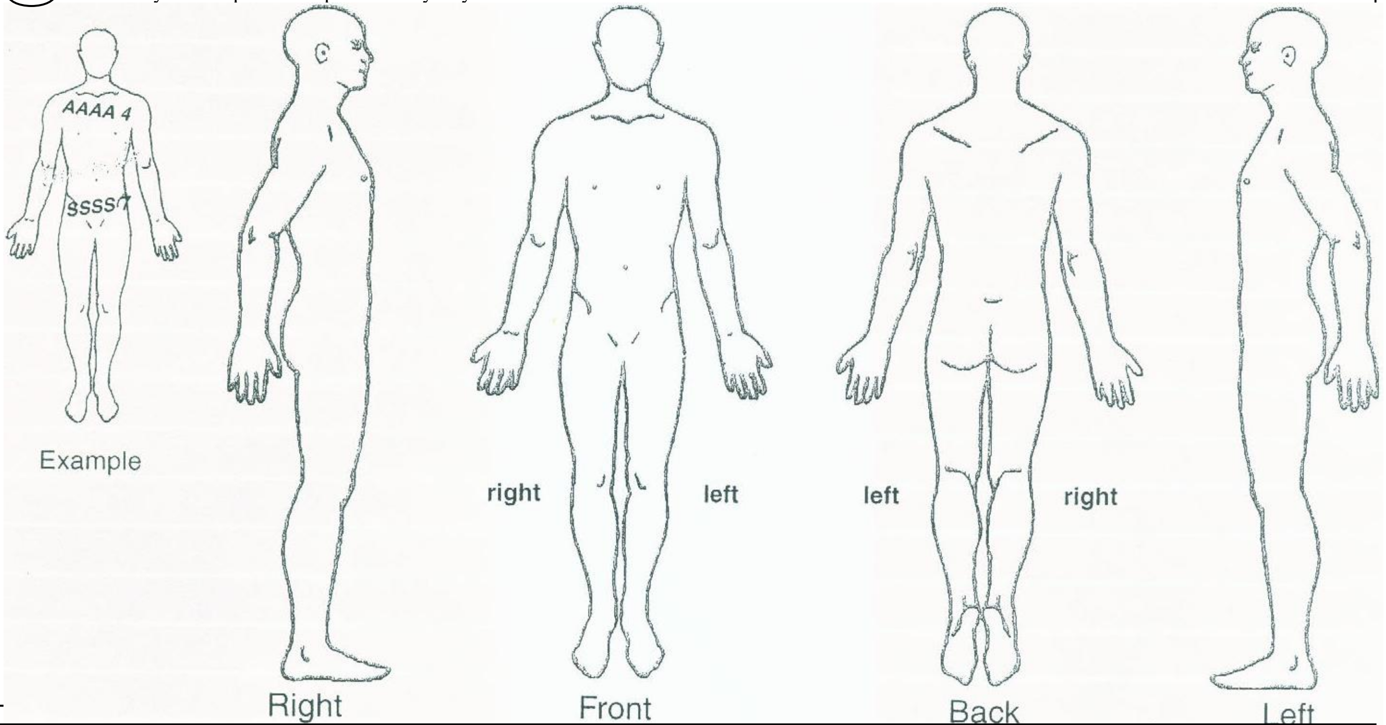
Signature: ____ Date: ______/______/_________

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury of discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol →	NNN	PPPP	BBBB	AAAA	SSSS

⬭ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

____

____

____

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DOCTOR'S NOTES

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FAULKNER
CHIROPRACTIC & WELLNESS

Informed Consent

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or Surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. IT is important to understand what to expect from chiropractic health care services.

ANALYSIS
A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found chiropractic adjustments and ancillary procedures may e given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although Doctor's of Chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal Medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure the other opinions if he/she has many concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as tot whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care of the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment of other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he/she is aware that such may contraindicated. Again, it is the responsibility of the patient to make it known or to learn though health care procedures whatever he/she is suffering from. Patient pathological defects, illnesses, or deformities; that would otherwise not come to the attention of the Doctor of Chiropractic provides a specialized, non-duplicating health services. The Doctor of Chiropractic is licenses in special practice and is available to work with other types of providers in your health regime.

RESULTS
The purpose of chiropractic services is to promote natural health though the reduction of the VSS or VSC. Since there are o many variables; it is so difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. in most cases there is a more gradual, but quiet satisfactory response. Occasional, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to al problems. Both have made great strides in alleviating pain and controlling disease.

I hereby certify, by my signature below, that the following statements are true
1) The injuries presented are real
2) Any statements, written, or oral, concerning any accident as a cause of my current condition is true.
3) I am in no way attempting to file, or have the doctor file, a false claim against my insurance carrier.
4) The driver's license and/or SS card presented are actual and are not forged or falsified.
5) I am not an agent representing other interests and am only interested in relieving treatment for legitimate health reasons.
6) The identity and the nature below are my legal identity and legal name.
7) I am personally responsible and legally liable for any suits, judgments, or legal proceedings including legal fees which are brought against this office or any of its employees as a result of false statements given.

____ _______________
SIGNATURE OF PATIENT OR GUARDIAN (IF A MINOR) DATE

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FAULKNER
CHIROPRACTIC & WELLNESS

FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. If you have insurance we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

We accept assignment on your insurance benefits. With your signature bellow we are able to send information to the insurance company and receive direct payment for your care. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We will accept cash, check, MasterCard, or Visa, Discover for your deductible and co-payment. Payment will be expected at the time of treatment unless other arrangements have been agreed to in writing. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." (usual, customary, and reasonable fees for this region.)
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that regardless of my insurance coverage, I am responsible for the balance on my account for any services rendered. Patient is responsible for late fees, attorney fees or any type of collection fees needed to collect on unpaid balances.

____ __________

Signature of Patient or Parent/Guardian Date

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NOTICE OF PRIVACY PRACTICES

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

THE PRIVACY OF YOUR HEALTH INFORMATION IS A PRIORITY OF Timothy Faulkner Chiropractic.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To Provide Treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office [procedures designed to optimize scheduling and coordination of care between all staff members. In addition, we may share your health information with referring physicians, clinical laboratories or other health care personnel providing you treatment.

To Obtain Payment: We may include your health care information with an invoice or billing summary to collect payment for treatment you receive in our office. We may do this with insurance forms filed to you in the mail or sent electronically. We may also use this information for the purpose of gaining insurance benefit information and an estimate of covered expenses. We will be sure to work only with companies with a similar commitment to the security of your heal information.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to court of administrative orders, subpoena, discover request, or other lawful process, under certain circumstances.

To Conduct Health Care Operations: Your health care information may be used during staff training and/or evaluation to provide the best possible care to our patients. It is also possible that health information may be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during routine processes of certification, licensing or credentialing activities.

In Patient Reminders: Because we believe regular care is very important to your general health, we will use your health information to contact you to remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and progress and inform you of treatment options and services that may be beneficial to you. Theses communications are an important part of our mission of partnering with our patients to provide the best benefits of chiropractic care. They may include letters, telephone reminders or electronic reminders such as email (unless you direct us that you do not want to receive these reminders as directed by your individual patient authorization.)

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading s disease 0r condition.

Family, Friends, and Caregivers: We may share your health information with those you tell us will be helping you with your hone care or financial responsibility for payment of your care.

Workers Compensation: WE may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

YOUR RIGHTS

To restrict use of your information within reason in writing.
To request communication preferences in writing.
To inspect your health information.
To express questions or complaints to us or to the Secretary of Health and Human Services.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Thank you very much for taking your time to review how carefully we are using your health information. If you have any questions, we want to hear from you. If you do not have any questions or concerns, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form in the enclosed stamped self addressed envelope we have provided for your convenience.

We will request at the time of your next visit for you to complete and sign an individual patient authorization for your permanent file. This form will allow you to exercise your right to express any limitations or concerns regarding the use and disclosure of your health information.

____ ___________________________

SIGNATURE OF PATIENT OR GUARDIAN (IF A MINOR) **DATE**

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Work and Auto Accident Form

FAULKNER
CHIROPRACTIC & WELLNESS

1

ABOUT YOU

Today's Date: _____/_____/_____ File #: ____________

Name: ____

2a

WORK RELATED ACCIDENT

Date & Time of Accident: __________________ ☐ a.m. ☐ p.m.

Was your accident directly related to your work? ☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident: ________________________________

____

____

Give the address where the accident occurred: ______________

____

Was anyone else present during your accident? ☐ Yes ☐ No

Did you report your accident to your employer? ☐ Yes ☐ No

What recommendations did your employer make immediately after your accident? ________________________________

____

Has this type of accident happened to you before? ☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? .... ☐ Yes ☐ No

In General:

Is your job physically stressful? .... ☐ Yes ☐ No
Is your job mentally stressful? .... ☐ Yes ☐ No
Is your workplace noisy? .... ☐ Yes ☐ No
Have you changed jobs in the last year? .... ☐ Yes ☐ No

2b

AUTO RELATED ACCIDENT

Date & Time of Accident: __________________ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued?

____

Number of people in accident vehicle? __________________
Did the police come to the accident site?................. ☐ Yes ☐ No
Was a police report filed?.. ☐ Yes ☐ No
Were there any witnesses?....................................... ☐ Yes ☐ No
Were you wearing your seat belt?............................ ☐ Yes ☐ No
Was this vehicle equipped with airbags?................. ☐ Yes ☐ No
If yes, did it/they inflate?... ☐ Yes ☐ No
In relation to the base of your skull, where was the headrest?
☐ Above ☐ Below ☐ At the base of the skull
What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: __________________________________
Did any part of your body strike anything in the vehicle?
☐ Yes ☐ No

If yes, please describe: ______________________________

____

Make and model of the vehicle you were occupying? _________

____

Name of the location/street on which you were traveling:

____

In which direction were you heading? ☐ N ☐ S ☐ E ☐ W

What was the approximate speed of your vehicle? ___________
Did the impact of your vehicle come from the:
☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other
During the impact, were you facing: ☐ Right ☐ Left ☐ Forward
Were you ☐ aware ☐ or surprised by the impact?
If accident vehicle made impact with another vehicle.......
Make and model of that other vehicle ____________________

____

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Speed of the other vehicle? ____________________________

In your words, please describe the accident: ______________

____

____

____

____

3

AFTER INJURY

Did the accident render you unconscious? ....☐ Yes ☐ No

If yes, for how long? ________________________________
Please describe how you felt immediately after the accident?:

____

____

Did you go to the hospital or see any other doctor? ☐ Yes ☐ No
When did you go? ☐Just after accident ☐ Next day ☐ 2 days plus
How did you get there? ☐ Ambulance or ☐ Private transportation

Name of Hospital and/or Attending doctor: _______________

____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D. O. ☐ D.D.S

Describe any treatment you received: ___________________

____

Were X-rays taken? .... ☐ Yes ☐ No
Was medication prescribed? .... ☐ Yes ☐ No
Have you been able to work since this injury?..... ☐ Yes ☐ No
Are your work activities restricted as a result of this injury?
☐ Yes ☐ No

Check all symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw Problems	☐ Nausea
☐ Memory Loss	☐ Irritability	☐ Arm/shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hand/finger	☐ Low back pain
☐ Blurred vision	☐ Tension	☐ Chest pain	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Shortof breath	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Stomach upset	☐ Numb feet/toes

☐ Other ____

Is your condition getting worse?
☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Have you retained an attorney?: ☐ Yes ☐ No

If yes, whom: ____

His/Her Phone #: ____

4

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal workday? ______________

Please check your daily job duties and any activities that you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other ____
What positions can you work in with minimal physical effort and

for how long? ☐ N/A ________________________________

____
Prior to the injury were you capable of working on an equal basis with others your age?....................................☐ Yes ☐ No ☐ N/A
Do you work with others who can help you with any heavy lifting?
☐ Yes ☐ No ☐ N/A
While in recovery is there any light duty work you can request?
☐ Yes ☐ No ☐ N/A

5

ADDITIONAL INSURANCE

2ND Insurance Source of Auto Insurance

Type of Insurance: ________________________________

Co. Name: ____

Address: ____

Phone Number: ____________________________________

Insured Name: _____________________________________

Policy #: __________________ Claim #: ________________

Insured's SS#: ______________ D.O.B. ______/______/______

Insured's Employer: ________________________________

Agent's Name: ______________________________________

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember, you are ultimately responsible for your account.

______________________________ _____/_____/_____
SIGNATURE DATE