

# APPLICATION FOR CARE AT INTEGRAL WELLNESS CO.

Today's Date: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF COMPLAINT

**PLEASE LIST** the **TOP FOUR** health conditions you are experiencing:

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

Using a scale of **0** to **10** with **0** being no pain and **10** being the worst pain, now rate the **TOP FOUR** conditions you listed above:

### Primary Condition Pain Level 0-10:

Right now: \_\_\_\_ At its worst: \_\_\_\_ At its best: \_\_\_\_ On average: \_\_\_\_

### Secondary Condition Pain Level:

Right now: \_\_\_\_ At its worst: \_\_\_\_ At its best: \_\_\_\_ On average: \_\_\_\_

### Third Condition Pain Level:

Right now: \_\_\_\_ At its worst: \_\_\_\_ At its best: \_\_\_\_ On average: \_\_\_\_

### Fourth Condition Pain Level:

Right now: \_\_\_\_ At its worst: \_\_\_\_ At its best: \_\_\_\_ On average: \_\_\_\_

**PLEASE MARK** the areas **ON** the body diagram with the following **letters** to describe the symptoms you feel:

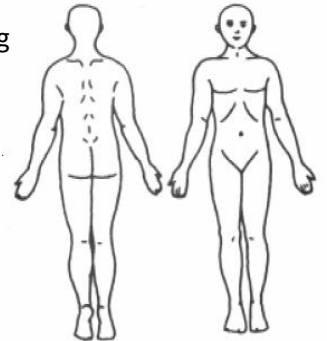
**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**

What relieves your symptom(s)? \_\_\_\_\_

What makes your symptom(s) feel worse? \_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_

How did the problem(s) begin? \_\_\_\_\_



List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

## REVIEW OF SYSTEMS

**CIRCLE all current health concerns you have.**

Headache	Left Rib Pain	Plantar Fasciitis	Anxiety	Frequent Ear Infections
Tension Headache	Upper Back Pain	Frequent Sickness	Depression	Ringing in Ears
Migraine	Mid Back Pain	Asthma	Hypothyroidism	Double Vision
Jaw Pain / TMJ	Low Back Pain	Difficulty Breathing	Hyperthyroidism	Fainting
Neck Pain	Right Sciatic Pain	Sleep Apnea	Chronic Fatigue	Epilepsy
Right Shoulder Pain	Left Sciatic Pain	Trouble Sleeping	Trouble losing weight	Dizziness / Vertigo
Left Shoulder Pain	Right Hip Pain	High Blood Pressure	Irritable Bowel	Fibromyalgia
Right Elbow pain	Left Hip Pain	Low Blood Pressure	Constipation	Numbness in arms
Left Elbow Pain	Right Leg Pain	Diabetes	Diarrhea	Numbness in hands
Right Wrist Pain	Left Leg Pain	Endometriosis	Reflux / Heartburn	Numbness in legs
Left Wrist Pain	Right Knee Pain	Sexual Dysfunction	Sinus Allergies	Numbness in feet
Right hand joint Pain	Left Knee Pain	PMS/Excessive Cramps	Food Allergies	Currently Pregnant
Left Hand Joint Pain	R. ankle/foot joint pain	ADHD	Eczema	
Right Rib Pain	L. ankle/foot joint pain	ADD	Psoriasis	

Other: \_\_\_\_\_

**If you have headaches or migraines:** Are they controlled by (go away with) medication or other treatment?  No  Yes

## PAST HISTORY

**Please circle any below that you have experienced in the past.**

Broken Bone    Fracture    Heart Attack    Cancer    Tumors    Sports Injury    Surgery    Stroke

Please describe: \_\_\_\_\_

## FAMILY HISTORY

**Any hereditary conditions you are aware of?**  No  Yes: \_\_\_\_\_

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

HR# \_\_\_\_\_

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES:**

**EFFECT:**

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sitting for extended periods	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Standing for ext. periods	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Bending Movement	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Exercise	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

(An Integral Team Member may help you with the table below.)

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

**INTEGRAL WELLNESS CO.**

**Informed Consent**

**REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Integral Wellness Co. have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

**REGARDING: X-rays/Imaging Studies for Females Only**

**FEMALES ONLY:** *Please read carefully, check the box, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Review**

# INTEGRAL WELLNESS CO. NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

## PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

## YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

## COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Micheal Bryan at (423) 299-1895. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

HR# \_\_\_\_\_

Patient initials: \_\_\_\_\_-retaining page 1 of 2

**INTEGRAL WELLNESS CO. NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...**

I have received a copy of Integral Wellness Co.'s Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
**PRINT Name**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**DATE OF BIRTH**

\_\_\_\_\_  
**Patient or Authorized Person's SIGNATURE**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

I hereby authorize payment to be made directly to Integral Wellness Co. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Integral Wellness Co. for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Examiner's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

HR# \_\_\_\_\_

## HIPAA Personal Health Information Release Authorization

I, \_\_\_\_\_, hereby authorize Integral Wellness Co. to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse                      Name: \_\_\_\_\_
- Significant Other            Name: \_\_\_\_\_
- Parent/Legal Guardian    Name: \_\_\_\_\_
- Child(ren)                    Name(s): \_\_\_\_\_
- Any Specified Person      Name: \_\_\_\_\_
- Information is not to be discussed with or released to anyone.

### Restrictions:

- No Restrictions
- Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

### Messages:

Please call     my home     my work     my cell phone

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- \_\_\_\_\_

I understand I may terminate this consent at any time by giving written notice to Integral Chiropractic Co. Any changes to this form will require a new consent form to be completed, signed, and dated.

\_\_\_\_\_  
**PRINT Name**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**DATE OF BIRTH**

\_\_\_\_\_  
**Patient or Authorized Person's SIGNATURE**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

HR# \_\_\_\_\_