American Wellness Center

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

Home Phone _____ Work Phone_____

Cell Phone _____ Cell Carrier (if you would like to receive text reminders) _____

Email Address: _____ How would like to be reminded of appointments? ☐ E-mail ☐ Text

Sex M F Date of Birth_____ Age_____ Social Security #_____

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

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other ____

Ethnicity ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino

Language ☐ English ☐ Spanish ☐ Other _____

Occupation_____ Employer_____

Referred by: _____

1. Reasons for seeking care: Is this visit due to an accident? ☐ Yes ☐ No If so, ☐ Auto ☐ Work ☐ Other

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____
_____
_____

3. Past Health History:

A. Please indicate if you have a history of any of the following:
□ Anticoagulant use □ Heart problems □ High blood pressure □ Chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Smoke Cigarettes □ Stroke/TIA's
□ Other _____ □ None of the above

B. Previous Injury or Trauma:_____

Have you ever broken any bones? Which? _____

C. Allergies: _____

D. Medications **Reason for taking**

_____
_____
_____
_____

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Patient Name: _____ Date: _____

E. Surgeries:

Date Type of Surgery

_____ _____

_____ _____

_____ _____

F. Females/ Pregnancies and outcomes:

Our consultation and examination may indicate the x-rays are necessary to accurately diagnose and analyze your conditions. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

□ There is a possibility that I may be pregnant at this time*

□ Yes, I am definitely pregnant

□ No, I am definitely not pregnant at this time

Date of last menstrual period:_____

*If there may be a possibility that you are pregnant, we would like to perform a urine pregnancy test prior to performing an x-ray to prevent any harm to your fetus.

Pregnancies/Date of Delivery Outcome

_____ _____

_____ _____

_____ _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death Age at death

_____

_____

_____

_____

Social and Occupational History:

A. Job description: _____

B. Work schedule:_____

C. Recreational activities:_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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Patient Name: _____ Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Chest congestion □ Wheezing □ Frequent sneezing
□ Chronic cough □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ High Blood Pressure
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ Slurring of speech
□ One-sided decreased feeling in the face or body □ Headaches □ Migraines □ Memory loss □ Tremors □ Vertigo
□ Loss of sense of smell/smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Bruise easily? □ Brittle nails?
□ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to this office for services performed.

Patient or Guardian Signature _____ Date_____

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American Wellness Center

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The practitioner, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the practitioner. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Signature of Patient/Guardian Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

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

_____ _____

Signature of Patient/Guardian Date

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Scottsdale, Arizona 85257 **Fax 480-946-2559**

American Wellness Center

Patient Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of American Physical Medicine and/or American Chiropractic Center. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine email address, text message, or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

NOTICE TO PATIENTS

A chiropractic physician must notify a patient that the physician has financial interest in a separate diagnostic or treatment agency to which the chiropractic physician is referring the patient and/or in the non-routine goods or services being prescribed by the chiropractic physician, whether such treatment, goods or services are available elsewhere on a competitive basis. R4-7-902.1. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are hereby advised that Lynn Genet, D.C. has a direct financial interest in American Physical Medicine, Inc. Further, the physical medicine services we have prescribed are available elsewhere on a competitive basis.

We ask that you acknowledge your having read and understood the disclosure contained in this notice by signing and dating this form in the spaces provided below. We will keep the signed original in your patient file.

ACKNOLEDGEMENT: I have read this "Notice to Patients" form, and I understand the disclosures that it contains.

_____ _____
Signature of Patient/Guardian Date

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Scottsdale, Arizona 85257

Phone 480-946-3399
Fax 480-946-2559

American Wellness Center

Patient Name: _____ **Date:** _____

DIAGNOSTIC X-RAY CONSULTATION SERVICES®

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Diplomate, American Chiropractic Board of Radiology
Fellow, the American Chiropractic College of Radiology

2525 West Carefree Highway, Building 2A, Suite 114
Phoenix, AZ 85085-9302
Telephone: (602) 274-3331
Fax: (602) 279-4445
www.diagnosticx-ray.com

PATIENT AUTHORIZATION AND ASSIGNMENT

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I understand that all charges from this consultation are ultimately my responsibility and separate from any charges at my Physician's office.

I authorize the release of any medical information necessary to process this claim. I also authorize the direct payment of medical benefits from group health, medical payments or third party payor to the physician for services described above. In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay collection agency fees up to a maximum of 21% of the outstanding balance at the time the account is placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court cost incurred for collection.

Date_____ **Patient's Signature** _____

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the x-ray examination of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated_____ **Patient's Signature**_____
(Parent or guardian if minor child)

Patient's Name_____
(Please print)

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said doctor named above.

Dated_____ **Attorney's Signature**_____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.

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Scottsdale, Arizona 85257

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