

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 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 Firm Title: _____

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 Employer: _____ /Address: _____.

Copay amount per visit? \$ _____ Percentage: ____/____%

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

Does your insurance limit the number of office visits you have in one year? Y / N Number: _____

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

Broken Bones / Surgical Procedures – please list area and year

I have never had any broken bones
Region _____ Year _____

I have never had any surgical procedures
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

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

*Infinite Wellness, Inc. 2014
817 N. Smithfield Rd.
Knightdale NC 27545*