Integrated WELLNESS
Get Well · Be Well · Live Well™

Application for Patient Care

PATIENT INFORMATION

First Name:_____ M.I.:_____ Last Name:_____ Date:_____

Address:_____ City: _____

State:_____ Zip:_____ Email: _____

Home #:_____ Cell #:_____ Work #: _____

SS#:_____-_____-_____ Age:_____ DOB: / /__ __ Male / Female

Primary Care Physician:_____

Do we have permission to contact your doctor regarding your care in our office?_____Yes_____No

Your preferred method of contact for appointment reminders? Email / Text by Cell Phone

Occupation:_____ Employer:_____

Type of Tasks Performed/Common Movements:_____

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

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation:_____ Phone #:_____

Preferred Language:_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit:_____

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient:_____ ☐ Walk-In/Drive-By

☐ Radio: _____ ☐ Internet:_____ ☐ TV:_____

☐ Ad:_____ ☐ Community Event:_____

☐ Insurance Company:_____ ☐ Other:_____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release **Method of payment for today's charges:____Cash ___Check ___Visa / MC**

I certify that I (or my dependent) have insurance coverage with_____and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Integrated Wellness South Jordan/Utah, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X)_____ **DATE** _____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, 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 these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. A finance charge of 1 ½% per month (annual rate of 18%) of the unpaid balance will be added monthly. I agree that I will be responsible for all attorney, collection, court and legal fees if legal action becomes necessary to collect this amount.

I have read and fully understand the above statements.

(SIGNATURE) (DATE)

FOR MINORS: I,_____ the parent or legal guardian of _____,
(Print Guardian Name) *(Print Minor's Name)*

I have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

(SIGNATURE) (DATE)

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____ Date of last menstrual period: _____

☐ There is a possibility that I may be pregnant at this time
☐ No, I am definitely not pregnant at this time
☐ Yes, I am definitely pregnant
☐ I request that x-ray films not be taken because:

_____ _____
Patient's Signature Date

PRIVACY NOTICE

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

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.
- We routinely send email and/or text message reminders of upcoming appointments. Email and standard SMS/text messages are not confidential methods of communication and may be insecure. You may opt out at any time. If you would prefer **not** to receive this type of communication, please initial here _____.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Randy Woodward. If you would like further information about our privacy policies and practices please contact: Dr. Randy Woodward.

This notice is effective as of January 1, 2014. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print)	*Signature*	*Date*

INTEGRATED WELLNESS

PRIMARY COMPLAINTS

Patient Name_____ Date ____/____/____

COMPLAINT (ie. Back, knee, neck, right shoulder, etc)	How often do you feel this complaint?	How long have you had this pain?	Is this issue getting	What makes it worse?	What helps? What have you tried?	How would you describe the pain?	Severity Now & At Its Worst	Circle all the ways this issue is affecting your life	Improving this issue would approve my quality of life by:
1.	Constant Daily Weekly "Off and On" Other: _____	_____ Day(s) Week(s) Month(s) Year(s) Flared up _____	Better Worse Staying the Same	Movement Lifting Sitting Standing Sit to Stand Computer Bending Driving Cough Sneeze Twisting Stairs Other: _____	Ice Heat Rest Braces Medication Movement Stretching PT Chiro Exercise Massage Other: _____	Dull Aching Sharp Burning Radiating Numbness Tingling Throbbing Tightness Other: _____	Now: _____/10 At Its Worst: _____/10	Job children sex marriage household hobbies finances sports exercise walking standing fatigue loss of sleep moody poor attitude loss of productivity	10-20% 30-40% 50-60% 70-80% 90% 100%
2.	Constant Daily Weekly "Off and On" Other: _____	_____ Day(s) Week(s) Month(s) Year(s) Flared up _____	Better Worse Staying the Same	Movement Lifting Sitting Standing Sit to Stand Computer Bending Driving Cough Sneeze Twisting Stairs Other: _____	Ice Heat Rest Braces Medication Movement Stretching PT Chiro Exercise Massage Other: _____	Dull Aching Sharp Burning Radiating Numbness Tingling Throbbing Tightness Other: _____	Now: _____/10 At Its Worst: _____/10	Job children sex marriage household hobbies finances sports exercise walking standing fatigue loss of sleep moody poor attitude loss of productivity	10-20% 30-40% 50-60% 70-80% 90% 100%
3.	Constant Daily Weekly "Off and On" Other: _____	_____ Day(s) Week(s) Month(s) Year(s) Flared up _____	Better Worse Staying the Same	Movement Lifting Sitting Standing Sit to Stand Computer Bending Driving Cough Sneeze Twisting Stairs Other: _____	Ice Heat Rest Braces Medication Movement Stretching PT Chiro Exercise Massage Other: _____	Dull Aching Sharp Burning Radiating Numbness Tingling Throbbing Tightness Other: _____	Now: _____/10 At Its Worst: _____/10	Job children sex marriage household hobbies finances sports exercise walking standing fatigue loss of sleep moody poor attitude loss of productivity	10-20% 30-40% 50-60% 70-80% 90% 100%
4.	Constant Daily Weekly "Off and On" Other: _____	_____ Day(s) Week(s) Month(s) Year(s) Flared up _____	Better Worse Staying the Same	Movement Lifting Sitting Standing Sit to Stand Computer Bending Driving Cough Sneeze Twisting Stairs Other: _____	Ice Heat Rest Braces Medication Movement Stretching PT Chiro Exercise Massage Other: _____	Dull Aching Sharp Burning Radiating Numbness Tingling Throbbing Tightness Other: _____	Now: _____/10 At Its Worst: _____/10	Job children sex marriage household hobbies finances sports exercise walking standing fatigue loss of sleep moody poor attitude loss of productivity	10-20% 30-40% 50-60% 70-80% 90% 100%
5.	Constant Daily Weekly "Off and On" Other: _____	_____ Day(s) Week(s) Month(s) Year(s) Flared up _____	Better Worse Staying the Same	Movement Lifting Sitting Standing Sit to Stand Computer Bending Driving Cough Sneeze Twisting Stairs Other: _____	Ice Heat Rest Braces Medication Movement Stretching PT Chiro Exercise Massage Other: _____	Dull Aching Sharp Burning Radiating Numbness Tingling Throbbing Tightness Other: _____	Now: _____/10 At Its Worst: _____/10	Job children sex marriage household hobbies finances sports exercise walking standing fatigue loss of sleep moody poor attitude loss of productivity	10-20% 30-40% 50-60% 70-80% 90% 100%

10376 South Jordan Gateway South Jordan, UT 84095 P: (801) 816-0332 F: (801) 816-0331 www.SouthJordanWellness.com

PATIENT HEALTH HISTORY

Please check if you have experienced in the last 6 months any of the following conditions

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Jaw Problems
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Tension across shoulders
- ❑ Foot trouble
- ❑ Carpal Tunnel
- ❑ Loss of handgrip strength?
- ❑ Do your legs or feet fall asleep regularly?
- ❑ Cold Sweats
- ❑ Weakness, numbness or burning in shoulder, arms or hands?
- ❑ Do your hands or arms fall asleep regularly?
- ❑ Weakness, numbness or burning in buttocks, hips, feet or legs?

Please check if you have every had any of the following at any time

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low
- ❑ Broken Bones
- ❑ Bulimia
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gall bladder
- ❑ Goiter
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Herniated Disc
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Menopausal Problems
- ❑ Migraines
- ❑ Mouth Sore or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prosthesis
- ❑ Rheumatoid Arthritis
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tumors/Growths
- ❑ Ulcers
- ❑ Other: _____

Have you taken any of the following for the above complaints in the last 6 months?
❑ Tylenol ❑ Ibuprofen/Advil/Motrin ❑ Aspirin ❑ Opiates ❑ Prescription Meds ❑ Injections ❑ Other _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No
If yes, explain _____

Please list any and all medications you are currently taking:
Medicine Name?_____Frequency?_____ Dose? _____ Why taking it? _____
Medicine Name?_____Frequency?_____ Dose? _____ Why taking it? _____
Medicine Name?_____Frequency?_____ Dose? _____ Why taking it? _____
Medicine Name?_____Frequency?_____ Dose? _____ Why taking it? _____
Please list any supplements you are currently taking (vitamins/herbs/minerals):_____
_____

ALLERGIES: please list know allergies food or other_____

Have you had an MRI or CT Scan? Y N
If so, when?_____Who ordered and why?_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____
_____
_____
_____
_____

Is there a family history of any of the following conditions? *(Indicate family member including parents, grandparents & siblings)*

❑ Heart Disease _____ ❑ Diabetes _____ ❑ Cancer _____ ❑ Arthritis _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine _____cups/day Alcohol_____drinks/week Cigarette_____pks/day

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker

Identify the major causes of stress in your life (i.e., work, family, legal, financial, emotion, etc.) _____

_____

Do you consider yourself (circle one): Underweight Overweight Just Right C urrent weight _____ ideal weight _____

Would you be interested in learning more about our Medical Weight Loss program? Y / N

Additional Symptoms or Concerns:

_____

_____

_____

_____

_____

_____

_____

Review of Systems

Name_____ **Date**_____

Please circle "Y" for Yes or "N" for No if you currently or in the past have had any of the symptoms below.

Neurological

Y N Migraines
Y N Headaches
Y N Slurring of speech
Y N Ringing in Ear
Y N Loss of Balance

Eyes/Ear/Nose/Throat

Y N Altered taste/smell
Y N Night Blindness
Y N Sore Throat
Y N Gingivitis
Y N Nose bleeds
Y N Blurred/Double Vision

Cardiovascular

Y N Chest pain
Y N Palpitations-racing heart beat
Y N Swelling in hands/feet
Y N Anemia
Y N Dizziness/Fainting
Y N Cold Extremities

Respiratory

Y N Recurrent Respiratory Infections
Y N Shortness of Breath
Y N Chest Congestion
Y N Wheezing
Y N Frequent Sneezing

GI

Y N Stomach Pains or Cramping
Y N Constipation/Diarrhea
Y N Reflux or Heartburn
Y N Bloating
Y N Gas
Y N Nausea or Vomiting

Musculoskeletal

Y N Joint Pain
Y N Arthritis
Y N Chronic pain
Y N Swollen Joints

Skin

Y N Eczema
Y N Dermatitis
Y N Excessive Sweating
Y N Rashes
Y N Brittle Nails
Y N Hair Loss
Y N Easy Bruising
Y N Increased Bleeding
Y N Numbness/tingling

Genitourinary

Y N Uterine fibroids
Y N Ovarian cysts
Y N Cancer (breast, ovarian, prostate, uterine)
Y N Prostate problems

Emotional/Mental

Y N Depression
Y N Anxiety
Y N Mood Swings
Y N Irritability
Y N Memory Loss
Y N Trouble Concentrating

Energy

Y N Fatigue
Y N Hyperactivity
Y N Restlessness
Y N Insomnia
Y N Decreased Libido
Y N Stress

Weight

Y N Decreased Appetite
Y N Recent Weight Change
Y N Inability to Lose Weight
Y N Food Cravings
Y N Binge Eating
Y N Water Retention

Please check ALL options you have previously tried to assist in the above symptoms:

____Over the counter medications
____Prescriptions
____Dietary Changes
____Exercise
____ Consult with specialist
____ Supplements
____ Alternative medication/treatment therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Y or N
If yes, what?_____ When?_____