WCW
Weaver Chiropractic Wellness

3151 Airway Ave, F-205
Costa Mesa, CA 92626
P: 949-416-5429 F: 949-299-0015
www.weaverchirowellness.com
info@weaverchirowellness.com

PLEASE PRINT LEGIBLY

Full Legal Name_____ Nick Name_____
Date of Birth_____ Age:_____ Female ☐ Male ☐
Address_____ City _____ State _____
Zip _____ Email Address_____
Cell Phone_____ Home Phone_____ Work Phone_____
What is the best way to reach you? ☐ Home ☐ Cell ☐ Text ☐ E-mail
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
Spouse's Name _____ Number of Children_____
Occupation _____ Employer _____
Business Address _____ City _____ State _____ Zip _____
Person to contact in case of emergency _____Phone_____
How did you hear about us? ☐ Friend/Family ☐ Insurance ☐ Yelp ☐ Ad ☐ Other _____
Do you have insurance? ☐ Yes ☐ No Insurance Company Name_____

Health Information

What is the reason for your visit today? ☐ Wellness ☐ Physical Complaint ☐ Accident ☐ Other_____
_____
What are your current physical complaints: _____
_____
When did your symptoms begin: _____
How is this condition changing? ☐ Getting Worse ☐ Getting Better ☐ Remained the same
What seems to increase the symptoms? ☐ Nothing ☐ Reaching ☐ Coughing ☐ Sitting ☐ Bending
☐ Standing ☐ Lifting ☐ Pulling ☐ Walking ☐ Turning ☐ Other: _____
What seems to diminish the symptoms?
☐ Nothing ☐ Ice ☐ Rest ☐ Heat ☐ Sitting ☐ Medication ☐ Stretching ☐ Exercise ☐ Standing
☐ Other: _____
How would you describe the pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Burning ☐ Tingling
☐ Cramping ☐ Stiff ☐ Swollen ☐ Stabbing ☐ Other:_____
Rate the severity of your pain. No Pain – 1 - 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 - Severe Pain
What other doctors and treatment have you received for this condition? ☐ None ☐ Chiropractor
☐ Medical Doctor ☐ Physical Therapist ☐ Specialist ☐ Other:_____

Women—Are you pregnant? ☐ Yes ☐ No If Yes, Estimated Due Date?_____ Nursing? ☐ Yes ☐ No
Place of Delivery_____ Doctor or Midwife_____

HEALTH HISTORY

List any medications you are taking and for what conditions_____
_____
List any vitamins/supplements/herbs you are taking_____
_____
List any doctors you are currently seeing_____
Have you ever been under the care of a chiropractor before today? ☐ No ☐ Yes, _____
Last visit? _____ Reason for leaving? _____
Allergies_____
_____

(Continue on Next Page)

HEALTH HISTORY (CHECK ONLY THOSE CONDITIONS WHICH YOU ARE <u>CURRENTLY HAVE</u> OR <u>HAVE HAD IN THE PAST</u>)

AIDS/HIV ☐
Alcoholism ☐
Anemia ☐
Anorexia / Bulimia ☐
Appendicitis ☐
Asthma ☐
Blood Clot ☐
Bleeding Disorders ☐
Breast Lump ☐
Bronchitis ☐
Cancer ☐
Candida ☐
Cataracts ☐
Chemical Dependency ☐
Chicken Pox ☐
Chronic Fatigue ☐
Depression ☐
Diabetes ☐
Emphysema ☐
Epilepsy ☐
Fibromyalgia ☐
Fractures ☐
General fatigue ☐
Glaucoma ☐
Gout ☐
Head Trauma(s) #_ ☐
Headaches ☐
Heart Disease ☐
Hepatitis ☐
Hernia ☐
Herniated Disc ☐
High Blood Pressure ☐
High Cholesterol ☐
Hemorrhoids ☐
Kidney Disease ☐
Measles ☐
Migraine Headaches ☐
Miscarriage ☐
Mononucleosis ☐
Multiple Sclerosis ☐
Mumps ☐
Night sweats ☐
Nervousness ☐
Osteoporosis ☐
Pacemaker ☐
Parasites ☐
Parkinson's Disease ☐
Pinched Nerves ☐
Pneumonia ☐
Polio ☐
Prostate issues ☐
Rheumatoid Arthritis ☐
Stroke ☐
Suicide Attempt ☐
Thyroid problems ☐
Tonsillitis ☐
Tuberculosis ☐
Tumors, growths ☐
Ulcers ☐
Vaginal Infections ☐
Varicose Veins ☐
Venereal Disease ☐
Vision troubles ☐
Other ☐ _____
Other ☐ _____
Other ☐ _____

List any surgeries you have had and the approximate dates:_____
_____ ☐ None
List any significant illnesses/hospitalizations you have had and the dates: _____
_____ ☐ None
List any auto accidents you have had and the dates: _____ ☐ None
List any traumas, significant injuries, concussions, unconsciousness, broken bones and dates: _____
_____ ☐ None

FAMILY HISTORY
List any family members that have died from anything other than old age, plus cause of death and age: _____
_____
List any illnesses, physical and/or mental impairments any of your relatives suffer from: _____
_____

DAILY HABITS
What type of exercise do you perform and how often? _____
Describe your daily work position/activities, for example: sitting, standing, light labor, heavy labor, computer work, driving _____
What is your typical diet? _____ Is it healthy and well balanced? Yes No
How many hours do you sleep per night? _____ Do you have troubles falling asleep? Yes No
Do you have trouble staying asleep (wake up often)? Yes NO How is your energy during the day? _____
Do you smoke? No Yes Amount per day? _____ How much liquor do you consume weekly? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____

AUTHORIZATION
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or I during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be personally be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____
SIGNATURE OF PATIENT or GUARDIAN DATE

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INFORMED CONSENT

Michelle Weaver D.C.
3151 Airway Ave, Ste F-205
Costa Mesa, CA 92626

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient Name _____

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Health Privacy Confidentiality Statement

Disclosure of Information

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Worker's Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment Reminder

It is our policy to email you regarding your scheduled appointment once the appointment as been made. It is also our policy to send text reminders to remind you of your appointment time. We will not email, text, or leave any message that discloses confidential information. If you would like to use an alternate contact number please inform us the number you would prefer.

Facility Set Up

While our examination rooms are private, our office utilizes an open adjustment/therapy/exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment of health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is no cost for the first copy and any copy thereafter is $25.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial amendment.
- You have the right to a copy of the notice upon request.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to J.R. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, SW Room 509F HHH
Building Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice.
By signing this form I provide authorization and consent to use and disclose my protected information as noted above.

Patient Signature (or legal guardian)_____

Print Patient Name_____

Date_____