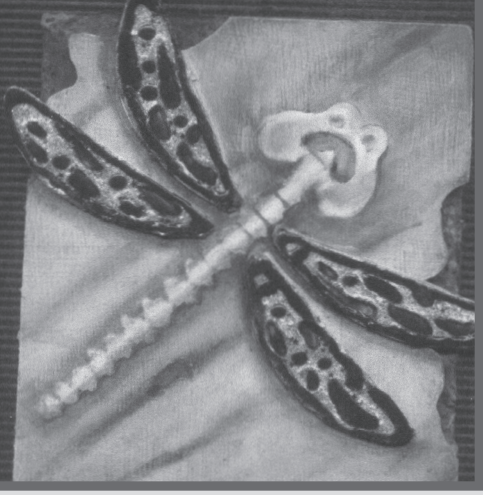

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ADVANCED WELLNESS CENTER

Dr. Susan Morris, *Chiropractor* | Dr. Renee M. Saverance, *Chiropractor*

Patient Information

Thank you for choosing Advanced Wellness Center for your chiropractic needs. If you have any questions, please ask for assistance. We will be happy to help.

NAME: **DATE:** / /

PATIENT DEMOGRAPHICS

Name	FIRST	MIDDLE	LAST		
Address	STREET				UNIT
	CITY		STATE	ZIP CODE	
Contact Info	HOME PHONE	CELL PHONE	WORK PHONE		
	PHONE PREFERENCE ☐ HOME ☐ CELL ☐ WORK		EMAIL		
Birth Date	MM	DD	YYYY	**Social Sec.**	XXX-XX-XXXX
Additional Info	GENDER ☐ MALE ☐ FEMALE	STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ PARTNER			

EMERGENCY CONTACT INFO

Name	FIRST	MIDDLE	LAST	
Address	STREET	CITY	STATE	ZIP CODE
Contact Info	PHONE (HOME, WORK, CELL)	EMAIL		
Relationship	CONTACT RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ PARTNER ☐ SIBLING ☐ FRIEND ☐ OTHER:			

RESPONSIBLE PARTY INFO

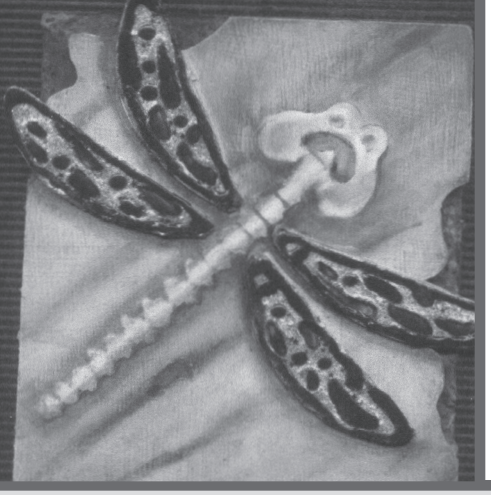
Name	FIRST	MIDDLE	LAST		
Address	STREET	CITY	STATE	ZIP CODE	
Contact Info	PHONE (HOME, WORK, CELL)	EMAIL			
Birth Date	MM	DD	YYYY	**Social Sec.**	XXX-XX-XXXX

EMPLOYER INFO

Name	PATIENT EMPLOYER / SCHOOL	OCCUPATION		DATE EMPLOYED
Address	STREET	CITY	STATE	ZIP CODE
Contact Info	WORK PHONE	EMAIL		

INSURANCE INFO

Name of Insured	FIRST	MIDDLE	LAST		RELATIONSHIP TO PATIENT
Birth Date	MM	DD	YYYY	**Social Sec.**	XXX-XX-XXXX
Insurance Co. Name	INSURANCE COMPANY		PHONE NUMBER	GROUP #	EMPLOYER #
Insurance Co. Address	STREET		CITY	STATE	ZIP CODE
Additional Info	HOW MUCH IS YOUR DEDUCTIBLE?	HOW MUCH HAVE YOU USED?		MAX. ANNUAL BENEFIT?	



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ADVANCED WELLNESS CENTER
Dr. Susan Morris, *Chiropractor* | **Dr. Renee M. Saverance**, *Chiropractor*

Acceptance of Chiropractic Care

NAME: **DATE:** / /

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments (subluxations) within the spinal column, which interfere with the body's ability to function at its maximum health potential. It is important that each patient understand both the objective and the method that will be used to attain our goal.

> **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of the mental impulse, resulting in a lessening of the body's innate ability to express its maximum health potential.
>
> **Adjustment:** An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
>
> **Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate ability to function. Our only method is by specific adjustments to correct vertebral subluxations.

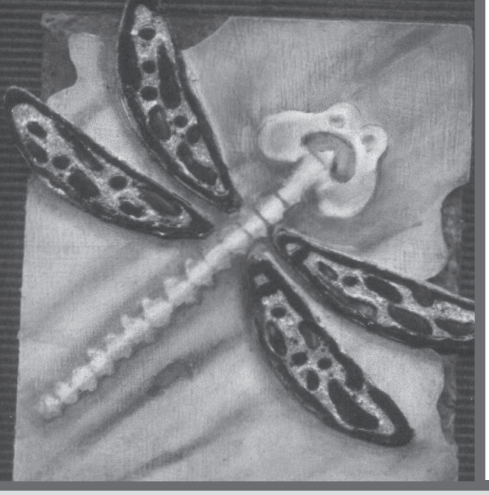
I, PLEASE PRINT _____ , have read the above statements and have had an opportunity to ask questions about it's content. All questions about the doctor's care pertaining to me in this office have been answered. The best health services are based on a friendly, mutual understanding between provider and patient.

Signature _____ **Date** / /

Consent to evaluate and adjust a minor

I, PLEASE PRINT _____ , being the parent or legal guardian of PLEASE PRINT _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature _____ **Date** / /



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ADVANCED WELLNESS CENTER
Dr. Susan Morris, *Chiropractor* | **Dr. Renee M. Saverance**, *Chiropractor*

HIPAA Disclosure Form

PURPOSE OF CONSENT

NAME: **DATE:** / /

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years.

This form is a "friendly" version. A more complete text is available in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.

https://www.hhs.gov/hipaa

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U. S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

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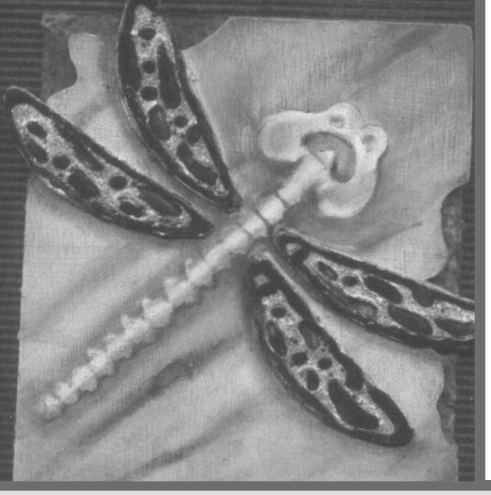

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ADVANCED WELLNESS CENTER
Dr. Susan Morris, *Chiropractor* | Dr. Renee M. Saverance, *Chiropractor*

HIPAA Disclosure Form

PURPOSE OF CONSENT — CONTINUED (PG. 2 OF 2)

NAME: **DATE:** / /

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

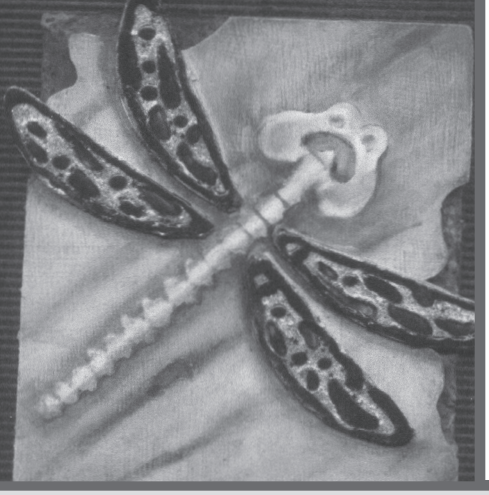
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, PLEASE PRINT _____ **, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

Signature PATIENT OR GUARDIAN **Date** / /

Witness Signature WITNESS **Date** / /

If you need additional information, please ask the front desk or refer to the web. Thank you.



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ADVANCED WELLNESS CENTER

Dr. Susan Morris, *Chiropractor* | Dr. Renee M. Saverance, *Chiropractor*

Health History

NAME: **DATE:** / /

Have you seen a Chiropractor before? YES ◯ NO ◯

IF YES, WHO WAS IT?

DID THE CHIROPRACTOR JUST:
- ☐ ADJUST YOU OR
- ☐ ADJUST AND INFORM YOU OF THE LIFESTYLE CHOICES AND HOW THEY AFFECT YOUR HEALTH

Have you seen a chiropractor or other medical provider prior to this visit? YES ◯ NO ◯

IF YES, PLEASE LIST?

How did you hear about the Advanced Wellness Center?

IF SOMEONE REFERRED YOU, PLEASE LET US KNOW WHO:

Are you currently on any medications? YES ◯ NO ◯

IF YES, PLEASE LIST ALL OVER THE COUNTER OR PRESCRIPTION MEDICATIONS:

Do you take vitamin supplements or herbs? YES ◯ NO ◯

IF YES, WHICH ONES?

Have you ever taken oral or IV antibiotics? YES ◯ NO ◯

IF YES, WHAT FOR?

How many glasses of water do you drink per day?

TOTAL

☐ BOTTLED ☐ TAP ☐ FILTERED ☐ DISTILLED

Other beverages and number of times per day?

TOTAL

Do you use artificial sweeteners? YES ◯ NO ◯

IF YES, WHAT KIND(S)?

Do you smoke? YES ◯ NO ◯

ADDITIONAL INFO
- ☐ FORMER SMOKER — WHEN DID YOU QUIT?

Do you drink alcohol? YES ◯ NO ◯

ADDITIONAL INFO
- ☐ FORMER — WHEN DID YOU QUIT?

Average hours of sleep per night?

TOTAL | POSITION | # OF PILLOWS

Regular structured exercise? YES ◯ NO ◯

IF YES, HOW OFTEN?

Do you take time to relax or meditate, or do breathing exercises? YES ◯ NO ◯

IF YES, HOW OFTEN?

Number of meals per day?

TOTAL | IF LESS THAN 3, WHICH ONES DO YOU SKIP?

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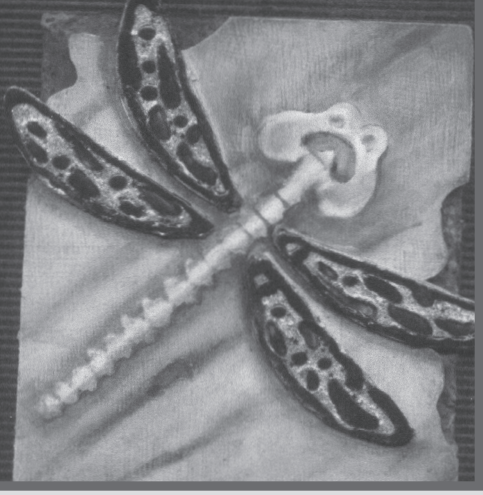

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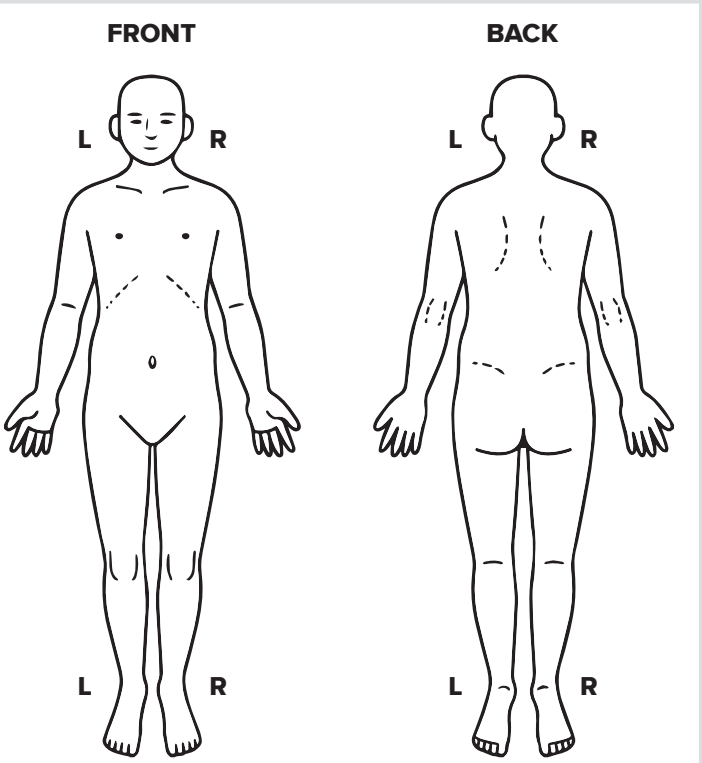
Dr. Susan Morris, *Chiropractor* | Dr. Renee M. Saverance, *Chiropractor*

Health History

CONTINUED (PG. 2 OF 3)

NAME: **DATE:** / /

What's going on today?
On the chart below, please an X on the area of the body you feel discomfort.



Complaint:

When did it start bothering you?

How did it happen?

Character of pain:

CHECK ALL THAT APPLY

☐ SHARP ☐ DULL ☐ TINGLING
☐ ACHY ☐ THROBBING ☐ WEAK
☐ DEEP ☐ SUPERFICIAL
☐ OTHER:

Does the pain radiate (travel)? ☐ YES ☐ NO

Where does it travel?

Pain is worse:

CHECK ALL THAT APPLY

☐ MORNING ☐ NOON ☐ NIGHT ☐ OTHER

What is your level of pain?

0 1 2 3 4 5 6 7 8 9 10
NONE ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ WORST

How has the pain affected your lifestyle?

0 1 2 3 4 5 6 7 8 9 10
NONE ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ SIGNIFICANT

Has the pain caused stress in your home or family life?

0 1 2 3 4 5 6 7 8 9 10
NONE ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ SIGNIFICANT

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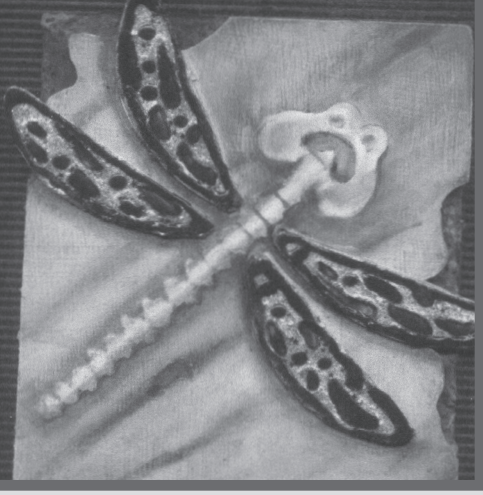

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ADVANCED WELLNESS CENTER

Dr. Susan Morris, *Chiropractor* | Dr. Renee M. Saverance, *Chiropractor*

Health History

CONTINUED (PG. 3 OF 3)

NAME: **DATE:** / /

Prior illness/condition:

Past hospitalizations & surgeries:

FAMILY HISTORY — Mother:

FAMILY HISTORY — Father:

Signature PATIENT OR GUARDIAN **Date** / /

FOR DOCTOR USE ONLY

EXAMINATION

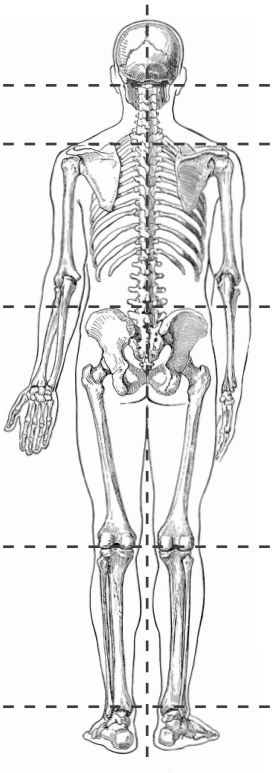
RANGE OF MOTION

CERVICAL	NORMAL		PAIN
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
LUMBAR	**NORMAL**		**PAIN**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

HEALTH HX NOTES:

ASYMMETRY

CO
C1
C2
C3
C4
C5
C6
C7
L1
L2
L3
L4
L5
SAC
L-IL
R-IL

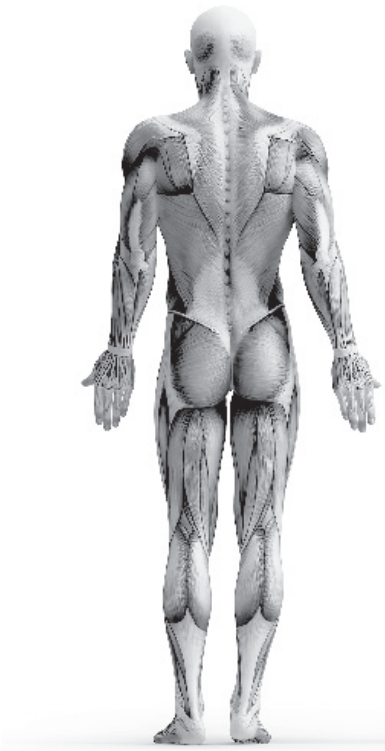


Using arrows (⬆ ⬇ ➡ ⬅) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (⬆ ⬇) mark postural asymmetry

TISSUE



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP = Trigger Point; LG = Ligaments (swollen or tender); TN = Tendons; SK = Skin; FS = Fascial Restrictions