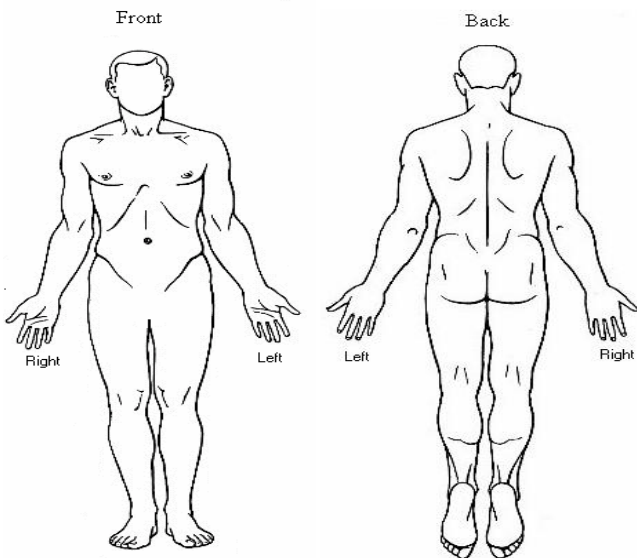


PERSONAL HISTORY

Name: _____ M F Date: _____ DOB: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Married Single Widow Divorced # Children: _____ Name of Spouse: _____
 E-mail Address: _____ Emergency Contact & Phone: _____
 Home Ph: _____ Cell Ph: _____ Work Ph: _____
 SSN: _____ - _____ - _____ Occupation _____ FT PT
 Employer: _____
 Primary Care Physician: _____ PCP Ph: _____ Is it OK if we contact them about your care **Y N**
 How did you learn about our office: Yellow Pages Online Mailer Friend Family Co-worker Physician Other
 If referred, by whom: _____

HEALTH INFORMATION

Reason for Today's Visit: _____
 Please list your complaints: 1. _____ 2. _____
 How did your complaint(s) begin: _____
 Date it began: _____ Developed over time Result of Accident: **Y N** Date of Accident : _____
 Is your condition getting worse: **Y N** Is your current complaint: Auto related Work related Other
 Other doctors seen for this condition: **Y N** Doctor's Name : _____
 Have you had: X-rays MRI CT Scan Other tests Dates taken: _____
 What areas were imaged: _____
 Previous Chiropractic Care: **Y N** If so, For what : _____
 Doctor's Name: _____ Last Date of Treatment: _____
 Please accurately mark all areas of discomfort / pain on the figure below using the *symbols* that best describe your symptoms.



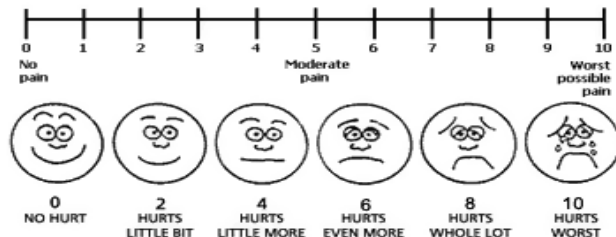
- Numbness – NN*
- Burning – BB*
- Dull Ache – DD*
- Tightness – TT*
- Pins & Needles – OO*
- Stabbing – XX*
- Spasm – SS*
- Other – Please Describe*

What percentage of the day do you feel pain?

Complaint 1. 0-25% 26-50% 51-75% 76-100%

Complaint 2. 0-25% 26-50% 51-75% 76-100%

What is your pain level at present?



Continued on Reverse Side →

Fitwell Chiropractic & Sports Therapy

14640 N. Tatum Blvd, Ste 7 Phoenix, AZ 85032 O: 602.867.7463 F: 602.867.7800

Name: _____ Age: _____ Date: _____

List all current medications and SUPPLEMENTS you are taking and for what: _____

Please check YES or NO for ALL of the following regarding your health:

- | | | |
|---|---|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease / Circulatory Issues
(explain) _____ | <input type="checkbox"/> <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> <input type="checkbox"/> Recent Fever |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Pregnant? # Weeks _____ | <input type="checkbox"/> <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain |
| <input type="checkbox"/> <input type="checkbox"/> Hives, Eczema, Rash | <input type="checkbox"/> <input type="checkbox"/> Taking Birth Control _____ | <input type="checkbox"/> <input type="checkbox"/> Thyroid <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper |
| <input type="checkbox"/> <input type="checkbox"/> Unusual Spots / Moles | <input type="checkbox"/> <input type="checkbox"/> STD _____ | <input type="checkbox"/> <input type="checkbox"/> Asthma / Difficulty Breathing |
| <input type="checkbox"/> <input type="checkbox"/> Cancer / Tumor (explain) _____ | <input type="checkbox"/> <input type="checkbox"/> HIV / AIDS Positive | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia (where) _____ | <input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> <input type="checkbox"/> Corticosteroid Use |
| <input type="checkbox"/> <input type="checkbox"/> Temperature / Pressure Sensitivity | <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> <input type="checkbox"/> Stress |
| <input type="checkbox"/> <input type="checkbox"/> Broken bones / Fractures: _____ | <input type="checkbox"/> <input type="checkbox"/> History of Head Injury | <input type="checkbox"/> <input type="checkbox"/> Wear Contacts |
| <input type="checkbox"/> <input type="checkbox"/> Surgeries / Hospitalizations: _____ | <input type="checkbox"/> <input type="checkbox"/> Headaches | Last physical-date: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Other health related issues: _____ | <input type="checkbox"/> <input type="checkbox"/> Bruise easily / Bleeding problems | |

Physical/Social History:

- | | | | |
|--|---|---|---|
| <i>Exercise</i> | <i>Work Activity</i> | <i>Habits</i> | <i>What does your pain effect?</i> |
| Y N | | Y N | Y N |
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting | <input type="checkbox"/> <input type="checkbox"/> Smoking-Packs/day _____ | <input type="checkbox"/> <input type="checkbox"/> Work |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Standing/bending | <input type="checkbox"/> <input type="checkbox"/> Alcohol-Drinks/week _____ | <input type="checkbox"/> <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Light labor | <input type="checkbox"/> <input type="checkbox"/> Caffeine-Drinks/day _____ | <input type="checkbox"/> <input type="checkbox"/> Daily Routines |
| <input type="checkbox"/> Days/week _____ | <input type="checkbox"/> Heavy labor | <input type="checkbox"/> <input type="checkbox"/> High stress | <input type="checkbox"/> <input type="checkbox"/> Recreation |
| | | | <input type="checkbox"/> <input type="checkbox"/> Sports _____ |
| | | | <input type="checkbox"/> <input type="checkbox"/> Playing with Kids |
| | | | <input type="checkbox"/> <input type="checkbox"/> Driving |
| | | | <input type="checkbox"/> <input type="checkbox"/> Concentration |

Family History:

Mother's Side:

- Y N**
- Cancer (type) _____
- Heart Disease - Age _____
- Stroke - Age _____
- High Blood Pressure
- Diabetes
- Rheumatoid Arthritis
- Other _____

Father's Side:

- Y N**
- Cancer (type) _____
- Heart Disease - Age _____
- Stroke - Age _____
- High Blood Pressure
- Diabetes
- Rheumatoid Arthritis
- Other _____

I understand and agree that health and accident policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Fitwell Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Fitwell Chiropractic will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I AM PERSONALLY responsible for payment. I also understand that if I suspend or terminate my care and treatment, ANY fees for professional services rendered to me will be immediately due and payable. I also understand and agree to give Fitwell Chiropractic Office, PLLC the POWER OF ATTORNEY to sign any insurance check mailed to the doctor with my name on the check for any services rendered at Fitwell Chiropractic Offices, PLLC I authorize payment of medical benefits to Fitwell Chiropractic Office PLLC for any and all services rendered. I also authorize the release of any information pertinent to my case to any insurance, adjuster, or attorney involved in this case. Furthermore, I have read and understand the Fitwell Chiropractic & Sports Therapy Notice of Privacy Practices.

Name of Person Responsible for Payment (Please Print): _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for FitWell Chiropractic to use and disclose protected health information (PHI) about myself to carry out treatment, payment and healthcare operations for TPO (treatment, payment, operation). FitWell Chiropractic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. FitWell Chiropractic reserves the right to revise its Notice Of Privacy Practices at anytime. A revised notice of Privacy Practices may be obtained by forwarding a written request to FitWell Chiropractic Privacy Officer at 14640 N. Tatum Blvd., Ste. 7 Phoenix, AZ 85032.

With this consent, FitWell Chiropractic may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying our Treatment, Payment Operations, such as appointments reminders, insurance items and any call pertaining to my clinical care, including results among others.

With this consent, FitWell Chiropractic may contact you for purposes described: birthday cards, thank you cards, e-mail correspondence, in office promotions and displaying your picture in the office.

Your health Information Rights:

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that (FitWell Chiropractic) is not required to agree to restriction that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect and copy your health information.
4. You have the right to request that FitWell Chiropractic amend your protected health information. If your request to amend your health information has been denied, you will be provided with and explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have the right to accounting disclosures of your protected health information made by FitWell Chiropractic.

This notice is effective as of ___/___/___

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide FitWell Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice.

Signature of Patient or Legal Guardian

Relationship to Patient

Patients name Printed

Date

Authorized Facility Signature

Date