CONFIDENTIAL PATIENT HISTORY

Date______________

Name____________________________________ DOB_________Sex____SS#_______________

Address___________________________________City_______________State____Zip________

Marital Status ☐M ☐S ☐W ☐D Spouse's Name___________________________# of children___

Phone (home)_____________________(cell)__________________(work)__________________

Email_______________________Occupation_________________Employer________________

Emergency Contact______________________Phone________________ Cell_______________

Preferred form of contact ☐work ☐home ☐cell ☐mail ☐email

Whom may we thank for referring you to this office?___________________________________

Have you had previous chiropractic care? ☐yes ☐no

Describe your experience____

Describe your present major complaints (rating pain on a scale of 1-10 with 10 being highest)

____ ____

____ ____

____ ____

Symptoms are worse ☐Morning ☐Afternoon ☐Night

How occurred____

____Date occurred________________

Symptoms developed from

☐Job related injury ☐Auto accident ☐Other accident ☐Illness ☐Unknown cause ☐Gradual Onset

Is this condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Is this condition interfering with the following? ☐Work ☐Sleep ☐Daily Routine ☐Other_______

Other doctors who treated this condition ____

List any complaints____

Have you ever been in an auto accident? ☐ Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Describe____

Have you had any other injuries or accidents (including fractures, dislocation, childhood trauma)?
☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Describe____

MEDICAL AND SOCIAL PATIENT HISTORY

Name____ Date_________________________

How long has it been since you felt really good?____

Family Physician_________________________________ Phone__________________________

List surgical operation and years ____
____

List medicines and supplements you take and the reason you take them____________________
____

Are you allergic to any medications? ☐Yes ☐No If yes, what kind? _________________________
Last physical examination__________________ (Men) Last prostate exam________________
(Women) Last pap smear________________ (Women) Last mammogram________________
(Women) Are you pregnant? ☐Yes ☐No If no, date of last menstrual period______________
MRI ____
CT Scan____
X-Ray____
List blood test or urinalysis by type and date ____
____

Habits (note daily amount)
Sleep ____________ Tobacco ____________ Coffee ____________ Tea ____________
Alcohol ____________ Recreational drug use ____________ Other ________________________
Activities (note type and time spent doing activity)
Exercise ____
Hobbies ____
Nutrition
How many meals do you eat a day?______ Are you happy with your nutritional state? ☐Yes ☐No

Other Health Concerns:
Have you been treated/evaluated for any health condition by a physician in the last year? ☐Y ☐N
If yes, what condition? ____
Have you lost or gained weight in the past year? ☐Yes ☐No If yes, how much? ___________
Have you felt emotionally down or unmotivated lately? ☐ Yes ☐No If yes, since when?_________
List any other information that might be helpful ____
____

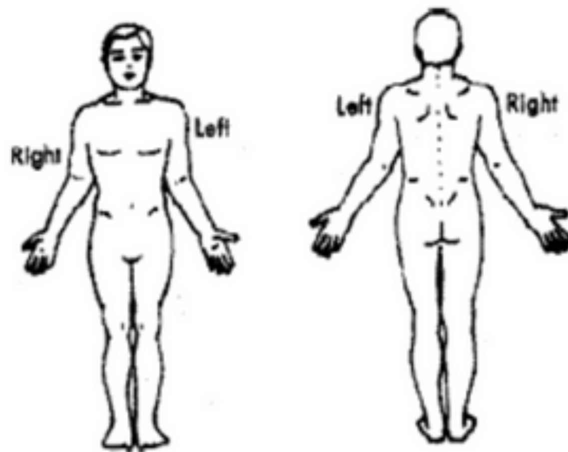
Are you wearing? ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Arch Supports ☐Full Orthotics

CONFIDENTIAL PATIENT HISTORY

Patient's Name:____

Have you had or do you now have any of the following symptoms which have been of significant distress to you?
Indicate by circling **N**: within the last 6 months **P**: never had in the past **X**: family history of condition

Headaches	N P X	Allergies	N P X
Cancer	N P X	Menstrual Issues	N P X
Depression	N P X	Memory Loss	N P X
Diarrhea	N P X	Anemia	N P X
Hemorrhoids	N P X	Constipation	N P X
Belching	N P X	Vomiting	N P X
Asthma	N P X	Stroke	N P X
Neck Pain	N P X	Seizures/Epilepsy	N P X
Back Pain	N P X	Weakness	N P X
Knee Pain	N P X	Cold Sweats	N P X
Arthritis	N P X	Indigestion	N P X
Swollen Joints	N P X	Colitis	N P X
Muscle Aches	N P X	Hernia	N P X
Scoliosis	N P X	Nervousness	N P X
Nerve Disease	N P X	Diabetes	N P X
Hot Flashes	N P X	Numbness/Tingling	N P X
Kidney Disease	N P X	Tremors/Twitching	N P X
Sleeping Problems	N P X	Urinary Tract Problems	N P X
Dizziness/Fainting	N P X	Triglycerides	N P X
Irritability	N P X	Heart Condition	N P X
Osteoporosis	N P X	Cholesterol	N P X
Cold Hands/Feet	N P X	Pulmonary Disease	N P X
Muscle Disease	N P X	Shortness of Breath	N P X
Easily Bruise and Bleed	N P X	Dental Problems	N P X
Thyroid Disease	N P X	Frequent Colds	N P X
Liver Disease	N P X	Gall Bladder	N P X
Sinus Problems	N P X	Upset Stomach/Ulcers	N P X
Ringing/Buzzing in Ears	N P X		



Use the symbols listed below to describe the location and type of pain or unusual feelings you are having by drawing them on the picture(s) above.

OOOO	Pins and Needles
XXXX	Numbness
//////	Pain
====	Other

FINANCIAL AGREEMENT

Patient Name: ____

Release of information
I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

Assignment of Benefits
I authorize and direct that payment be made directly to Dr. Kwon Blue Mountain Wellness Clinic for any and all insurance benefits or reimbursement for services rendered by him which amounts otherwise be payable to me under any insurance or pre-paid health care plan.

Payment Agreement
I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. All deductibles and co-payments are due at the time of service. I understand that if I do not have insurance, I will be responsible for full payment at the time of service. For your convenience, credit cards, debit cards or HSA accounts can be applied towards payment. If you are unable to pay the entire balance, payment arrangements can be made. Please contact our office.

Massage no show/cancellation policy
We do everything we can to provide the best possible service to all our clients by adhering to a schedule to the best of our abilities. When a client fails to make their appointment time, or cancels at the last minute, that time slot is wasted which could have been used for another patient needing treatment. Given this fact, we require a twenty-four hour cancellation notice. If a client cancels without sufficient notice, we will be forced to charge a $30.00 late cancellation/no show fee.

(We understand that life is complicated. In the event of reasonable unexpected life events, or illness, we will waive this policy. *This is at the discretion of the scheduled therapist.* Please phone our office so we can work with you to arrange treatment. This policy is only in place to encourage common courtesy.)

Patient Signature____ Date__________________

Signature____ Date__________________
(Responsible party if under 18

HIPAA

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes;
organ donation purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Blue Mountain Wellness Clinic will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his/her authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Name of person(s) I authorize my health information to be disclosed to:

Name ___________________________________ Relationship__________________

Name ___________________________________ Relationship__________________

Name ___________________________________ Relationship__________________

I <u>DO NOT</u> authorize Blue Mountain Wellness Clinic to use the following methods of contacting me:

☐ Home phone ☐ Leave message (appointments, health info.)

☐ Work phone ☐ Email

☐ Cell phone ☐ Texting Cell Phone

☐ To receive mailings such as birthday post cards, information regarding wellness discussions and/or classes.

Patient Signature____ Date___________________

Signature____ Date___________________
(Responsible party if under 18)

Informed Consent of Examination and Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulations are required by law to obtain your informed consent before starting treatment.

I____________________________________, of_______________________________
(name) (City, State)

do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of examination and manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercise may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing

Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medication, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or

short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest in not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____	____________________________________
Patient's Name	Witness
____	____________________________________
Patient's Signature (or Responsible Authority)	Date

Consent to treat a Minor
I hereby request and authorize Dr. Kwon Blue Mountain Wellness Clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent or Guardian signature: ____

Parent or Guardian: ____

Date: ______________________ Witness: ____

ACUPUNCTURE & ORIENTAL MEDICINE INFORMATION & INFORMED CONSENT

ACUPUNCTURE INFORMATION

I have been informed by the clinicians at Dr. Kwon Blue Mountain Wellness Clinic that acupuncture is performed by the insertion of pre-sterilized disposable acupuncture needles through the skin. A treatment may also consist of the application of heat and/or electrical stimulation to the skin at certain points on the body.

BENEFITS AND RISKS

The benefits and risks of receiving acupuncture and oriental medical treatments have been explained to me. As a result, I understand the following information:

Certain side effects, although rare, may result from acupuncture. They include but are not limited to:

1) Minor bleeding
2) Minor bruising
3) Needle sickness
4) Broken needles
5) Some pain around the points of needle insertion
6) Risks of infection
7) Minor burning
8) Potential side effects of nutritional supplements and herbs

Female Patients:

☐ I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period ____.

☐ I do hereby state that I am pregnant and to the best of my knowledge, I am _______ (weeks).

Patient Name (printed)____

Patient Signature: ____

CONSENT TO TREAT A MINOR CHILD

I authorize Dr. Kwon Blue Mountain Wellness Clinic and whomever he designates as assistants to perform acupuncture and oriental medicine care as deemed necessary to my _______________________ (relationship).

Parent/Guardian Signature: ____Date: _________________________