WELCOME

PATIENT INFORMATION

Date:_____

Name:_____
Address:_____
City:_____State:_____ZIP:_____
Sex ❑ M ❑ F Age: _____Birth Date:_____

❑ Single ❑ Married ❑ Widowed ❑ Divorced
SS#:_____

Occupation:_____
Employer:_____
Employer Address:_____
City:_____State:_____ZIP:_____

Spouse's Name:_____
Whom may we thank for referring you?

INSURANCE INFORMATION

Name of Insured:_____
Birth Date:_____SS#:_____
Relationship to Patient:_____
Insurance Company:_____
ID or Policy #:_____
Plan or Group #:_____
Address:_____
City:_____State:_____ZIP:_____
Does patient have additional insurance? ❑ Y ❑ N
Name of Insured:_____
Birth Date:_____SS#:_____
Relationship to Patient:_____
Insurance Company:_____
ID or Policy #:_____
Plan or Group #:_____
Address:_____
City:_____State:_____ZIP:_____

PHONE NUMBERS

Home:_____Cell:_____
Work:_____Ext:_____
Best time & place to reach you:_____
E-mail address:_____
May we send cards, promotions, etc. to you? ❑ Y ❑ N
IN CASE OF EMERGENCY, CONTACT:
Name:_____
Relationship:_____
Home #:_____Cell:_____
Work #:_____Ext:_____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No
Date of Accident:_____
Type of Accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you reported your accident?
❑ Auto Insurance ❑ Employer ❑ Other

Claim #:_____
Contact Person:_____
Attorney Name (if applicable):_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Draney Chiropractic, LLC will aid in preparation of 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 Draney Chiropractic, LLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I am aware and agree to pay a minimum finance charge of 1.5% per month (annual percentage rate of 18%) or a minimum of $2.00, whichever is more on any amount not paid after 30 days. If collection is made by suit or otherwise, patient and/or responsible party agree to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs. If any portion of this bill or the providers services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs of doing so

NAME (PRINT):_____SIGNATURE:_____DATE:_____
(Parent if patient is under 18 years of age)

PAST MEDICAL HISTORY		
❑ AIDS/HIV	❑ HIGH CHOLESTEROL	❑ PROSTATE PROBLEM
❑ ACID REFLUX DISEASE	❑ IRRITABLE BOWEL	❑ RECENT INFECTION/FEVER
❑ ARTHRITIS	❑ KIDNEY DISEASE	❑ RHEUMATIC FEVER
❑ ASTHMA	❑ LIVER DISEASE	❑ SCARLET FEVER
❑ BLEEDING DISORDER	❑ MENTAL DISORDER	❑ STROKE
❑ CANCER	❑ METAL IMPLANTS	❑ THYROID DISEASE, ↑ ↓
❑ CHRON'S DISEASE	❑ MIGRAINES	❑ TUBERCULOSIS
❑ DIABETES	❑ MONONUCLEOSIS	❑ TUMORS/GROWTHS
❑ EPILEPSY	❑ MULTIPLE SCLEROSIS	❑ ULCERS
❑ FREQUENT HEADACHES	❑ OSTEOPOROSIS	❑ ULCERATIVE COLITIS
❑ HEART DISEASE	❑ PACEMAKER	❑ URINARY PROBLEM
❑ HEPATITIS	❑ PARKINSON'S	❑ VENEREAL DISEASE
❑ HERNIA	❑ PINCHED NERVE	❑ OTHER
❑ HERNIATED/BULGING DISK	❑ PNEUMONIA	❑ OTHER
❑ HIGH BLOOD PRESSURE	❑ POLIO	❑ OTHER

IF YOU CHECKED ANY CONDITIONS ABOVE, **BRIEFLY EXPLAIN & INCLUDE WHEN YOU WERE DIAGNOSED** WITH THE CONDITION.

WHO IS & WHERE IS YOUR PRIMARY CARE PHYSICIAN?

SURGERIES/HOSPITALIZATIONS ❑ N/A		
MO/YEAR	SURGERY/HOSPITALIZATION	HOSPITAL/DOCTOR

MAJOR INJURIES/FRACTURES/CAR CRASHES ❑ N/A		
MO/YEAR	BRIEFLY DESCRIBE INCIDENT & INJURIES	HOSPITAL/DOCTOR

PATIENT'S NAME _____ DATE _____

MEDICATIONS ❑ N/A			
NAME	DOSE (mg)	FREQUENCY	SUPPLEMENTS/VITAMINS:
			❑ Aspirin ❑ Birth Control ❑ Blood Thinners

ALLERGIES TO MEDICATIONS ❑ N/A			
NAME	REACTION	NAME	REACTION

SOCIAL HISTORY		
EXERCISE	❑ Sedentary (no exercise)	❑ Occasional (1-3 hours per week)
	❑ Regular (4-5 hours per week)	Activity:
WORK ACTIVITY	❑ Sitting ❑ Standing ❑ Light Labor	❑ Heavy Labor
SEX	Are you sexually active? ❑ Yes ❑ No	If yes, are you trying for pregnancy? ❑ Yes ❑ No
ALCOHOL	Do you drink alcohol? ❑ Yes ❑ No	How many drinks per week?
TOBACCO	Do you use tobacco? ❑ Yes ❑ No	How many packs per day?
	Number of years OR	Number of years since quitting?
COFFEE/CAFFEINE	Do you drink coffee/caffeine? ❑ Yes ❑ No	How many cups/ounces per day?
STRESS LEVEL	❑ High ❑ Moderate ❑ Low	Do you feel you handle your stress well? ❑ Y ❑ N
SLEEP	❑ Back ❑ Side ❑ Stomach Do you use a pillow designed to support your neck?	How many hours do you get on average per night? ❑ Yes ❑ No
HANDEDNESS	❑ Right ❑ Left ❑ Ambidextrous	

FAMILY HEALTH HISTORY					
	AGE	MAJOR HEALTH PROBLEMS		AGE	MAJOR HEALTH PROBLEMS
FATHER			CHILDREN	❑ M ❑ F	
MOTHER				❑ M ❑ F	
SIBLING	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F			❑ M ❑ F	
SOME EXAMPLES OF SIGNIFICANT HEALTH PROBLEMS INCLUDE CANCER, STROKE, DIABETES, THYROID DISORDERS, HIGH BLOOD PRESSURE, HEART DISEASE, & OSTEOPOROSIS.					

PATIENT'S NAME

DATE

REVIEW OF SYSTEMS					
	CONSTITUTIONAL		**HEAD/NECK**		**CHEST/HEART**
❑	Fever	❑	Neck pain	❑	Chest pain
❑	Weight loss/gain	❑	Headaches	❑	Palpitations
	HEMATOLOGICAL		**LUNGS**		**ENDOCRINE**
❑	Bleeds/bruises easily	❑	Shortness of breath	❑	Cold/heat intolerance
❑	Enlarged glands	❑	Cough	❑	Lymph node swelling
❑	Past blood transfusion			❑	Menopausal
	EYES		**EARS/NOSE**		**MOUTH/THROAT**
❑	Eye pain/burning	❑	Hearing loss	❑	Sore throat
❑	Loss of vision	❑	Ringing	❑	Grinding teeth
❑	Double vision	❑	Nose bleeds	❑	TMJ disorder/jaw clicks
	GASTROINTESTINAL		**SKIN**		**BACK**
❑	Nausea/vomiting	❑	Rashes/lesions	❑	Low back pain
❑	Abdominal pain	❑	Eczema	❑	Leg pain
❑	Rectal bleeding	❑	Breast lump		
	GENITOURINARY		**NEUROLOGICAL**		**PSYCHIATRIC**
❑	Urinary frequency	❑	Memory changes	❑	Depression
❑	Burning with urination	❑	Difficulty walking	❑	Anxiety
❑	Sexual function problems	❑	Slurred speech	❑	Bipolar
❑	Frequent bladder infections	❑	Numbness	❑	Panic Attacks
		❑	Dizziness/Lightheadedness	❑	Insomnia
		❑	Weakness		

IF YOU CHECKED ANY CONDITIONS ABOVE, BRIEFLY EXPLAIN:

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW?

IMPORTANT DATES & QUESTIONS (ANSWER THOSE THAT APPLY)	
Last physical exam?	Last menstrual cycle?
List when, where, and of what part you have had any recent x-rays, MRI, CT, or other imaging studies taken:	Last pap smear?
	Are you pregnant? ❑ Y ❑ N If yes, due date?
	Number of pregnancies? Number of miscarriages?

DOCTOR'S NOTES

PATIENT'S NAME _____ DATE _____

PATIENT CONDITION

Reason for visit:
What is the most recent cause of the problem?
Was there an old injury that originally started the problem? ❑ Yes ❑ No
If yes, briefly describe:
When did your symptoms or this episode begin?
Are your symptoms: ❑ getting worse ❑ getting better ❑ about the same
Have you had similar symptoms in the past? ❑ Yes ❑ No If yes, when?
What treatment did you receive? ❑ Meds ❑ Physical Therapy ❑ Chiropractic ❑ Surgery ❑ Other
Did treatment improve your condition? ❑ Yes ❑ No
How long did your treatment last?
Name and location of any doctors/therapists who have treated your condition:

Mark the pictures below with appropriate symptom abbreviations listed on the right side.

Dull/Achy	DDDDD
Throbbing	TTTTTT
Numbness	NNNNN
Cramping	CCCCC
Sharp/Shooting	SSSSSS
Burning	BBBBB
Tingling	XXXXX
Stiffness	///////////

Circle the severity of pain on average & at the worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (ER type of pain)

The pain is: ❑ constant ❑ off and on daily ❑ off and on during the week ❑ only with certain movements
Is the pain worse: ❑ in the morning ❑ during the day ❑ in the evening ❑ at night
Does it interfere with: ❑ work ❑ sleep ❑ daily routine ❑ recreation
Does it wake you up at night? ❑ Yes ❑ No
Have you lost time from work? ❑ Yes ❑ No If yes, list dates: _____
What makes this condition better? _____
What makes this condition worse? _____
Does the pain travel to another location? ❑ Yes ❑ No If yes, where? _____

_____ _____
PATIENT'S NAME DATE

Legacy Chiropractic & Wellness Center
Shanon Nelson, D.C.
826 E 12300 S Suite 4, Draper, UT 84020

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power, and authority.

RELEASED INFORMATION: You are authorized to release and permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character as needed for treatment, payment, and health care operations.

ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, and other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABLILITY: If patients(s) treatments for injuries are the result of the negligence of any third party, then patients(s) grant a lien against any recovery from **any source, including first, second, or third party**, to the extent of the bills for treatment in favor of the physician/facility named above.

STATUTE OF LIMITATIONS: Patients(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection including attorney fees and court costs, if incurred. I also agree to pay a minimum finance charge of 1.5% per month (annual percentage rate of 18%) or a minimum of $2.00 whichever is more on any amount not paid after 30 days. If collection is made by suit or otherwise, patient and/or responsible party agree to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signatures of Patients and Responsible Party:

Sign Here 1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

Legacy Chiropractic & Wellness Center
Dr. Shanon Nelson
826 E 12300 S Suite 4, Draper, UT 84020
801-523-2233

Law requires us to obtain your informed consent prior to examination and treatment. By signing this document you are confirming that you have read and/or the doctor has discussed with you the following information, you have had an opportunity to ask questions and all your questions have been answered fully and satisfactory.

Associates and Assistants- In this office we may use trained staff to assist the doctor with portions of your consultation, examination and treatment. Occasionally, when your doctor is unavailable, another clinic doctor may treat you.

Treatment- An adjustment is performed by the doctor using her hands or mechanical device on your body in such a way as to move your joints. This procedure may cause an audible "click", much as you have experienced when you "crack" your knuckles. There are some inherent risks involved in doing this and they are as follows:

Pain: Most patients come to this office in pain. Rarely will treatment even temporally increase soreness in the region being treated. However, since it is possible, this is included in this section.

Rib Fracture: It is possible to "crack" an arthritic rib with an adjustment. This can happen with anyone. It occurs most often in aging patients who have weakened bones with osteoporosis. These problems occur so rarely, it is difficult to find available statistics to quantify their probability.

Disc Herniations: Occasionally, treatment will aggravate or cause a problem if the disc is in a weakened state. These problems occur so rarely, it is difficult to find available statistics to quantify their probability.

Physical Therapy: Some of the machines we use generate heat. We also use ice in this office. Burns can possibly come from such treatment. If you have a pacemaker or metal in your body, notify the doctor prior to therapy. These problems occur so rarely, it is difficult to find available statistics to quantify their probability.

Stokes: Strokes are not that common, and even less so in a chiropractic office. They are so rare that you have a greater chance of getting hit by lightning-less than one in three million. This office reduces your odds even further through screening tests during your examination.

Other Problems: There may be other problems or complications that might arise from treatment such as massage, traction, etc. These problems or complications are so infrequent that it is not plausible to anticipate and/or explain them all in advance.

Non-Treatment- Remaining untreated results in adhesions, pain and reduction in associated joint mobility. The probability that adhesions and pain will interfere with motion, function, and quality of life is almost certain.

I hereby state that I have read, or have had read to me this consent form. I authorize and direct the above named physician, associates and/or assistants to provide such additional services as they may deem reasonable and necessary

Patient's Printed Name:_____ Patient's Signature:_____ Date:_____

Legacy Chiropractic & Wellness Center
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801-523-2233

Standard Authorization of Use and Disclosure of Protected Health Information

Information to be Used or Disclosed
The information covered by this authorization includes:

- Appointments
- Account and Billing Information
- Personal Health Information
- Treatment Recommendation

Persons Authorized to Use or Disclose Information
Information described above may be disclosed to:

_____

_____

I acknowledge that I have been informed and given the opportunity to review the Notice of Privacy Practices for Legacy Chiropractic & Wellness Center. I also acknowledge that I have been given the option to receive a copy of this Notice.

Patient Name:_____ Date:_____