



Dr. Dwight L. Agee
Dr. Lauren P. Cobb

CHIROPRACTIC AND WELLNESS CENTER, P.C.

Name: _____ "Nickman" _____

Address: _____ Apt: _____

City _____ State: _____ Zip: _____

Date of Birth _____ Age _____ Gender: M F Ht. _____ Wt. _____

Social Security # _____ Home Phone: (_____) _____

E-Mail _____ Cell Phone: (_____) _____

Marital Status: S M W D Number of Children _____ Occupation _____

College Student Y/N Spouses Name _____

Responsible Party _____ Relationship _____ DOB _____

Address _____

How did you hear about us? TV Phonebook Newspaper Website Sign

Friend/Family Member _____ Other _____

In case of emergency please contact _____ Relationship _____

Phone # _____

Are you currently under the care of a physician or other health care professional? Yes / No

If yes, please give name and date of last visit _____

Do you exercise on a regular basis? Yes / No If yes, please explain what kind of exercise you do: _____

What kind of dental work have you had? _____

Have you had yeast infections? If so, when was the last one _____

Do you crave sugar/sweets? Yes / No How often do you have these cravings? _____

How would you rate your sleep? (please circle one) Poor Fair Good Great

How if your energy/strength/stamina (please circle one) Poor Fair Good Great

How is the health of your spouse? _____

Do your children have any health concerns? _____

How can we make you happier? _____

I, _____ (Patients Name) hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to AGEE CHIROPRACTIC AND WELLNESS CENTER, P.C. (the "center") such sums as benefits, health and accident, benefits workman's compensation benefits, or any other insurance benefits obligated to reimburse me or form any settlement judgment or verdict on my behalf as may be necessary to adequately protect said center. I understand that I remain personally responsible for the total amounts due to the center for their services. I further understand and agree this assignment, lien and authorization does not construe any consideration for the center to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that I am financially responsible to the center for all charges not covered by my insurance company. I further agree that in the event of non-payment, I will bear the cost of collection fees (331/3% of balance), and/ or court cost and reasonable legal fees, should this be required. I authorize the center to release any information pertinent to my case to my insurance company, adjuster, or attorney or 3rd party-review board, employer- to facilitate collection under this Assignment, Lien and Authorization. I agree that the able mentioned center may be given power of attorney to endorse/sign my name on ant and all check for payment of services rendered. I hereby authorize the center (or whomever they may designate as assistants), to administer such treatment as is necessary, and to perform the appropriate therapy, manipulation, and additional diagnostic procedures as considered chiropractically necessary on the basis of findings. This serves as a long-term authorization that applies to all occasions of service until it is revoked.

Patient Signature

Date

Witness Signature

Listed below are the persons, including all of my medical doctors, who are involved in my care with whom you may share my protected health information regarding my treatment or payment issues:

Name/Relationship/Phone Number: _____

X _____

Patient Signature (or Parent if Minor Child)

Date

I _____ (Name of Individual) consent to Agee Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or the treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practices, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my right and the Practice's duties regarding the types of uses and disclosures of my Protective Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has active in reliance on this consent.

X _____

Patient Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Patients Name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Agee Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

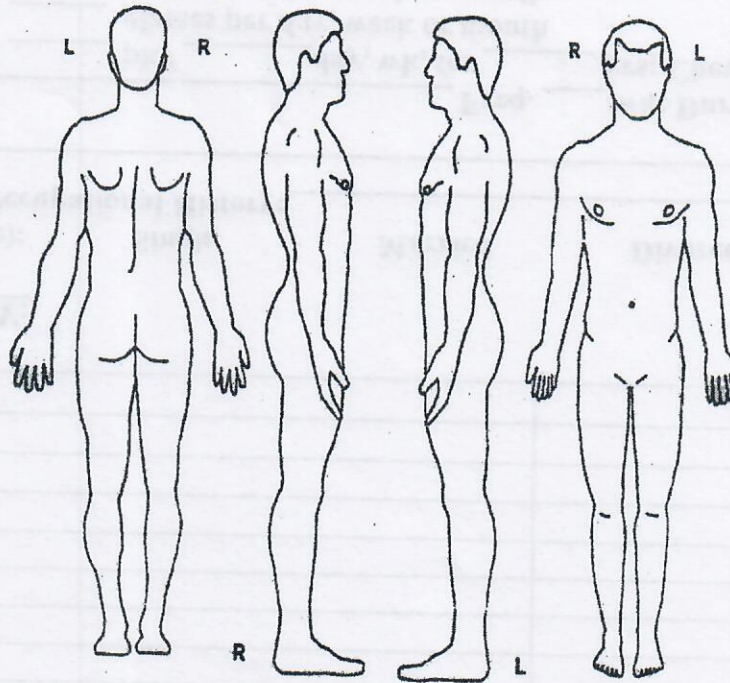
Patient Signature

Date

Witness Signature

PATIENT NAME: _____ DATE: _____ PN: _____

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please mark an X beside any of the symptoms/conditions listed below that you CURRENTLY are experiencing.

- | | | |
|---|--|---|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bursitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Heart Murmurs |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Sleep Loss | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Depression/Nervousness |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Tingling/Numbness | <input type="checkbox"/> Difficult Breathing |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Inability to Control Bladder | <input type="checkbox"/> Kidney Infection or Stones |
| <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Sinus/Hay Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Heat/Cold Intolerance | <input type="checkbox"/> Painful Menstruation | <input type="checkbox"/> Loss of Interest or Energy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Pain/Swelling/Stiffness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Excessive Hunger/Thirst | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Glasses/Contact Lens | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Back or Neck Pain |
| <input type="checkbox"/> Swallowing Difficulties | <input type="checkbox"/> Muscle Pain/Cramps | <input type="checkbox"/> Stress (Emotional) |
| <input type="checkbox"/> Speech Problems/Hoarseness | <input type="checkbox"/> Irritable | <input type="checkbox"/> Seizures or Convulsions |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Easy Bruising or Bleeding |

PAST HISTORY

I. PAST MEDICAL HISTORY:

Prior MAJOR Illnesses: _____

Prior Surgeries/Operations: _____

Prior Hospitalizations: _____

Current Medications: _____

Allergies (Drug/Food): _____

Prior MAJOR Injuries (MVA, WC, SLIP/FALL, BROKEN BONES): _____

II. FAMILY HISTORY: * Please tell us if there is a History of Cancer, Diabetes, Cardiac Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain, Back Pain or Surgeries in your FAMILY.

Family History	Living? Medical problems if any:	Deceased? Cause of death:	Age
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Children			
Children			

III. SOCIAL HISTORY:

Marital Status (Circle): Single Married Divorced Widowed

Current Employment/Occupational History: _____

Exercise: Type: _____ Freq. _____ /wk; Duration _____ Min. / Hrs; _____

Tobacco: NO / YES _____ pk / _____ day, wk, for _____ yrs; Chew _____ yrs; Pipe _____ yrs

Caffeine: NO / YES _____ glasses per day, week or month

Alcohol: NO / YES _____ glasses per day, week or month

Sleep Interrupted? NO / YES _____ x's / night for _____ mo, yrs

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____