New Client Information

Today's Date_______________

PERSONAL INFORMATION

Name: ______________________________ Age: _________ Date of Birth: ______________________

Nickname or preferred name: ____

Home / Mailing Address: ____________________ City: _______________ State: _______ Zip: _________

Home Phone: (_____) __________________ Cell Phone: (_____) ______________________

email address: __________________________________

Occupation: ________________________ Employer / School: ____________________________

Work Phone: (_____) __________________ Work Status: ☐Full-time ☐Part-time ☐Seasonal ☐Other

In case of an Emergency – Contact: ________________________ Relationship: ____________________

Home Phone: (_____) __________________ Cell Phone: (_____) ______________________

Marital Status: ☐S ☐M ☐D ☐W ☐ Other _________ Number of Children *(if any)* & ages: ____________________

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? ____

Do you have a Primary Care Physician? ☐Y ☐N Would you like Functional Wellness to provide progress reports or information to your PCP or other practitioners? *If yes*: Full Name of Practitioner ____________________________________

HEALTH INFORMATION

HEALTH CONCERNS: Please list your top health concerns / complaints that you would like to address (in order of priority):

1) ____

2) ____

3) ____

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work / School:	Y	N	Recreation:	Y	N	Sleep:	Y	N
Exercise / sports:	Y	N	Walking:	Y	N	Sitting:	Y	N
Eating:	Y	N	Intimate/Personal Life:	Y	N	Other:	Y	N

HEALTH CARE PRACTITIONER HISTORY:

Have you ever received Chiropractic care? ☐Y ☐N When: ______________________________

Where: ____________________ Doctor(s) name(s): ________________________________

How long under care: ___________ Date of last visit: _________ Why did you stop? __________________

Was there a particular health concern(s) for which you consulted the chiropractor? ____________________________

Did you find the treatments helpful?____

Have you consulted or do you regularly consult any of the following care providers? *(check all that apply)*

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Physical Therapist ☐Dentist

☐ Nutritionist ☐ Personal Trainer ☐ Other: ____

Comments (conditions, treatments, success, etc.) ____

____

____

MEDICAL HISTORY: – Please check all that apply (**P** = Past / **C** = Current):

P / C

☐ ☐ Abdominal Pains
☐ ☐ Ankle/Foot Pain
☐ ☐ Blurred Vision
☐ ☐ Chest Pressure
☐ ☐ Clammy Hands
☐ ☐ Confusion
☐ ☐ Constipation
☐ ☐ Convulsions
☐ ☐ Dizziness
☐ ☐ Dry Mouth
☐ ☐ Earache
☐ ☐ Elbow/Hand Pain
☐ ☐ Excessive Thirst
☐ ☐ Eye Pain
☐ ☐ Facial Pain
☐ ☐ Fainting
☐ ☐ Fatigue
☐ ☐ Feel Loss of Control
☐ ☐ Forgetfulness

P / C

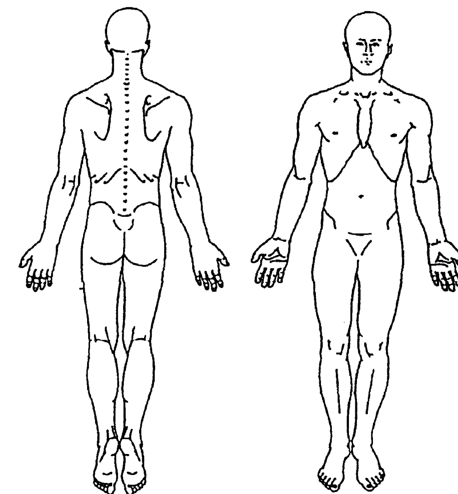
☐ ☐ Frequent Urination
☐ ☐ Fullness of Bladder
☐ ☐ Headache
☐ ☐ Hemorrhoids
☐ ☐ High Blood Pressure
☐ ☐ Hip Pain
☐ ☐ Insomnia
☐ ☐ Irritability
☐ ☐ Knee Pain
☐ ☐ Joint Stiffness
☐ ☐ Low Back Pain
☐ ☐ Low Blood Pressure
☐ ☐ Lump in Throat
☐ ☐ Menstrual Irregularities
☐ ☐ Nausea/Vomiting
☐ ☐ Neck Pain
☐ ☐ Paralysis
☐ ☐ Persistent Coughing
☐ ☐ Poor Appetite
☐ ☐ Poor Circulation

P / C

☐ ☐ Rapid Heart Rate
☐ ☐ Shakiness
☐ ☐ Shoulder Pain
☐ ☐ Sinusitis
☐ ☐ Slow Heart Rate
☐ ☐ Sore Muscles
☐ ☐ Sore Throat
☐ ☐ Swallowing Pain
☐ ☐ Swollen Ankles
☐ ☐ Sweating
☐ ☐ Swollen Joints
☐ ☐ Teeth Grinding
☐ ☐ Tingling in Feet
☐ ☐ Tingling in Hands
☐ ☐ Urination Difficulty
☐ ☐ Walking Problems
☐ ☐ Weak Muscles
☐ ☐ Other:____________
____
____

Please use the legend below to indicate any areas in which you feel the listed sensations

Stabbing - ||| **Tingling - :::**
Burning – XXX **Cramping - ^^^**
Numbness - === **Dull / Ache - ###**



Women only: # of pregnancies: ___________ # of birth children: ____________ # of C-Sections: ____________________

Age of children (if any): _____________________ Breast fed? ☐Y ☐N How long (each child) ? ______________________

Age of menarche (periods began): __________ Are you experiencing perimenopause? ☐Y/☐N Reached Menopause ☐Y/☐N

Is there any chance you might be pregnant? ☐Y ☐N Date of last menstrual cycle: _____________________________________

Do you currently, or have you used any of the following? (please circle all that apply) Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive

Length of use of each type? _________________________________ Have you ever had an abnormal PAP? ☐Y ☐N

HEALTH & FAMILY HISTORY:

Height:____________________ Weight:_______________________ Recent Weight Loss / Gain? _________________________

Reason / method for weight loss / gain: ____

Difficulty falling asleep? ☐Y ☐N Difficulty staying asleep? ☐Y ☐N Tired after full night's sleep? ☐Y ☐N

Crave sugar / salt? ¨ ☐Y ☐N Fatigue after meals? ☐Y ☐N Lightheaded / irritable when hungry?☐Y ☐N

Need coffee / sweets 3-4pm? ☐Y ☐N Do you eat Breakfast? ☐Y ☐N Usual breakfast foods:________________________

What time do you eat Breakfast? ____________________________ What time do you eat Lunch? _________________________

What time do you eat Dinner? _______________________________ Do you eat snacks? ¨Y/¨N Types:_____________________

Identify any conditions that **you**, or any of **your family members** have now or have had in the past:

(**X** = Self, **G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings)

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Depression/Anxiety
___Diabetes
___Eczema/Psoriasis
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart disease
___HIV/AIDS
___Hepatitis A/B/C
___Herpes
___High Blood Pressure
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Stroke
___Tumor(s)
___Ulcer(s)
Other: ___________________
____
____

Do you wear corrective lenses? ¨Y ¨N Date of last check-up / prescription change? __________________________________

Physical, chemical, structural and emotional stresses, common to our contemporary lifestyles, can result in dysfunction of the areas surrounding and involving the nervous system (the body's primary system which co-ordinates health}. The following may be seemingly insignificant events, however they may be contributing to today's experiences of health and wellbeing. Please feel free to add anything not listed here, and to ask any questions you may have regarding this section.

ACCIDENTS: Have you had any accidents related to any of the following? (check all that apply)

☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse ☐Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Have you ever injured any of the following regions? (check all that apply)

☐Head ☐Neck ☐Rib/Chest ☐Back ☐Pelvis/Hip ☐Arm/Hand ☐Leg/Foot

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

HOSPITALIZATIONS / SURGERIES: Please detail any hospitalizations, serious illnesses or surgeries

Year	**Reason**	**Hospital**	**Outcome**

MEDICATIONS: Please list all medications you are currently taking (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Who Prescribed?**

NUTRITIONAL SUPPLEMENTS: Please list all Vitamins and Nutritional supplements you are currently taking

Supplement	Brand and Amount Consumed	Date Started	Prescribed by anyone?

ALLERGIES: Please check and list all allergies

Food: ____________________

Medications: ____________________

Seasonal/Latex/Other: ____________________

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Rec. Drugs	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	______	
	8+ hrs	**7-8 hrs**	**6-7 hrs**	**5-6 hrs**	**<5 hrs**	
Sleep	☐	☐	☐	☐	☐	
	5+	**4**	**3**	**2**		
Meals/day	☐	☐	☐	☐		
	8+ cups	**4-7 cups**	**2-4 cups**	**<8 oz**		
Water/day	☐	☐	☐	☐		

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐Walking/Moving ☐Driving

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

Have you traveled in the last six to twelve months? ☐Y ☐N If yes: Where, for how long? ____________________

____

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Slavin prior to, during or after your appointment.

____

____

Patient Name Printed ____________________ Patient Signature ____________________ Date ____________________

Parent and/or Guardian Printed ____________________ Parent and/or Guardian Signature ____________________

Functional Wellness LLC
720 S. Colorado Blvd, Denver, CO 80246
PO BOX 85, Edwards, CO 81632
Phone: 970-376-7779 ~ Fax: 888-376-6372

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY

EFFECTIVE: SEPTEMBER 22, 2013

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.

Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Jacqui Slavin

Address: 720 S. Colorado Blvd, Denver, CO 80246 ~ PO BOX 85, Edwards, CO 81632

Telephone: 970-376-7779

Fax: 888-376-6372

Email: functionalwellness@live.com

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Functional Wellness LLC's Notice of Privacy Practices, which has an effective date of September 22, 2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

____ ____________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

Financial Policy

Due to the specialty and nature of our services at Functional Wellness, LLC patients are responsible for payment at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

We make every effort to work with your general practitioner for routine lab work, and provide the most competitive options for specialty testing, especially those that accept most insurance plans.

Payments made for services rendered at Functional Wellness, LLC can also be applied toward your annual deductible, and should be eligible expenditures for Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). We are happy to provide you with standard documentation and coding required by your provider / coverage entity. (Detailed documentation may be subject to standard hourly rate.)

We encourage patients to understand your individual health insurance policy and to contact your provider for clarification of benefits and reimbursement procedures prior to services being rendered. Many chiropractic procedures, as well as nutritional consultations may be covered by traditional policies, however this differs greatly by provider and network.

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call our office prior to the time of your appointment to make appropriate arrangements. If you arrive more than 10 minutes late to your scheduled appointment, you may be asked to reschedule.

Fee Schedule	
Cancellation, Missed Appointments and Late Arrivals	If you need to cancel an appointment, we kindly request that you allow at least 24-hours notice so that your appointment may be given to another patient who may be in need of urgent care. If we do not receive 24-hours notice there will be a $150.00 cancellation fee billed for an average length appointment. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
Returned Check Fee	There will be a $35 charge for all returned checks.
Collection Fee	If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the child's medical costs, it is the authorizing parent's responsibility to collect from the other parent.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

____________________________________ ______________________________

Signature of Patient or Responsible Party Date

____

Printed Name of Patient

Authorization Agreement For Pre-arranged Payment by Credit Card

I the undersigned hereby authorize Functional Wellness to initiate debit entries to the credit card at the financial institution listed below in the event of (1) missed appointments in the amount of $150.00; (2) returned checks in the amount of $30.00; (3) payment for services rendered outside of the office (including but not limited consultations by phone or Skype); (4) purchase of products (and or shipping fees, and sales tax) from Functional Wellness that was shipped / delivered or picked up during a time the office was not open for business; (5) payment for laboratory fees ordered by Functional Wellness on my behalf.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I further understand that this authorization will remain in full force and effect until I give this clinic written notice 15 days and I authorize a $30 service charge for any returned or unpaid debits or payments from my bank or credit card. With my signature, I warrant that I am an authorized signer and have authority to enter this agreement.

Name: ____ Date: ____________________

Billing Address: ____

City: __________________________________ State: __________________ Zip: ___________________

Please Circle one:

VISA **MASTERCARD** **AMEX** **DISCOVER**

Account Number: ____

Security Code: ______________________ Expiration Date (mm/yy): _______________________

Signature of Patient / Guarantor____