Chiropractic Wellness
By Dr. George Tomes, LLC
George Tomes, D.C.

PATIENT GENERAL INFORMATION QUESTIONAIRE

****Please Print Clearly. Please complete ALL information on this form (7 pages).****

Today's date: ________/________/______ *Please help us to spell your name correctly by block printing it!*

PERSONAL INFORMATION

First Name ________________________________ Middle Initial ________ Last Name ____________________________________

Address ____Apt. #________________

City ____ State ________________Zip __________________

Home Phone _____________________________________Work Phone _________________________________Ext ________

Cell / Mobile Phone ________________________________Best number to call for appointment reminders________________

E-mail____

Birth date_______________________________ Age__________Sex: ☐ Male ☐ Female Height ________Weight _______

Occupation ____Employer_____________________________________

If patient is a minor, parent / guardian name(s): ____

Emergency Contact Name ___________________________________Phone ____

Referred by (how did you hear about us?): ____

FINANCIAL INFORMATION

Person responsible for payment ☐ Self ☐ Auto Insurance (coverage must be verified)

Method of payment ☐ Cash ☐ Check ☐ Credit Card

I (we) agree to pay for services rendered to the abovementioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payments of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature____ Date ___________________________

Or Guardian Signature ____ Date___________________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Name:____**Date:**___________________________

CHIEF COMPLAINT/REASON FOR VISIT

____

____

Are you currently involved in a lawsuit or pending litigation over an injury? Yes ☐ No ☐ Date___________

Please check all conditions that in your past medical history involving injuries, surgeries, or medical treatment.

Condition		Have you had any auto or other accidents? Yes ☐ No ☐ Describe below.
Ankle pain	☐	
Arm pain	☐	
Back pain	☐	
Foot pain	☐	
Hand pain	☐	
Hip pain	☐	
Joint stiffness	☐	
Leg pain	☐	
Elbow pain	☐	

Please check all conditions that apply to you or your family's past medical history.

Condition	You	Family	Condition	You	Family
Arthritis	☐	☐	Asthma	☐	☐
Broken bones	☐	☐	Cancer	☐	☐
Chest pain	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Dizziness	☐	☐
Epilepsy	☐	☐	Eye/vision problems	☐	☐
Fainting	☐	☐	Fatigue	☐	☐
Genetic spinal condition	☐	☐	Headaches	☐	☐
Hearing problems	☐	☐	Hepatitis	☐	☐
High blood pressure	☐	☐	Multiple Sclerosis	☐	☐
Neurological problems	☐	☐	Pace maker	☐	☐
Parkinsons	☐	☐	Polio	☐	☐
Prostate	☐	☐	Significant weight change	☐	☐
Stroke/heart attack	☐	☐			

DRUGS, MEDICATIONS, SUPPLEMENTS

Current medications/drugs being taken, including "over the counter" medications: (use a separate sheet if needed:)

DRUG NAME	Taken for what symptom or condition	Taken how often?	Approx. starte date (or years ago)	Are you experiencing any side effects?

Name:____ **Date:**______________________

Please list any dietary supplements that you take regularly:

____

____

List any allergies or foods/substances you are sensitive to:

Allergy		Allergy	
Animals	☐	Aspirin	☐
Bees	☐	Dairy	☐
Drugs	☐	Dust	☐
Eggs	☐	Foods	☐
Latex	☐	Molds	☐
Rag weed/pollen	☐	Rubber	☐
Seasonal allergies	☐	Shell fish	☐
Soaps	☐	X-ray dye	☐
Other	☐		

Name, address and phone number of medical doctor:

____

__________**Date of last visit and why?**

____

DIET AND LIFESTYLE: **(LEAVE NOTHING BLANK)**

Caffeine ☐ Yes ☐ No ☐ in the past
Alcohol: ☐ Yes ☐ No ☐ in the past

Cigarettes/tobacco use: ☐ Yes ☐ No ☐ In the past
If yes, _________ Times per day How long? ______________________________
Recreational drugs: ☐ Yes ☐ No ☐ In the past
If yes, what kinds and how often?____

SOCIAL HISTORY:

Are you ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Domestic Partner

Number of Children: ________________ Number of Children Living in Household:
____

Please check your educational level:
☐ High school/GED ☐ Some college ☐ College graduate
☐ Trade school ☐ Graduate degree

Revised 2/14/10

Name:____Date:______________________________

THIS NOTICE IS PRESENTED IN COMPLIANCE WITH FEDERAL HIPAA REQUIREMENTS FOR HEALTH CARE PROVIDERS & DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

We Will Keep Your Medical Information Confidential. We will act to keep your health related information private except that you allow us to release pertinent information to:

1. Your insurance company or other 3rd party payer, so they can pay your bill.
2. Your other doctors, for information you want them to have from us.
3. Your attorney, or anyone else you request and authorize us to release it to.
4. Our business partners. Examples: Outside billing companies, outside marketing companies that might produce and mail our newsletters, etc. If we use any such company, they too will maintain the same level of privacy we maintain.
5. Your legal representative(s), should you for any reason become unable to speak and or act for yourself in making health care related decisions.
6. Your providers of emergency treatment as consistent with our awareness of your needs and the doctors best judgment. Example: You are in the emergency room and they need medical information about you from us.
7. Your family, friends or others that may answer your phone, read your mail, or otherwise communicate with us as part of our exchanging information with one another that is necessary to your care and relationship with this office. Examples: We can call your home and leave a message for you on your answering machine or with any person that answers. We can send you a fax or e-mail that might be read by any other person with access to your fax or e-mail. We can leave a message for you at work on any recording device or with any person limited to our name, phone number, and the level of necessity / urgency that you contact us.

APPOINTMENT REMINDER, BIRTHDAY CARDS & NEWSLETTERS The Practice may contact you to provide appointment reminders, information on treatment alternatives or other health related information, offers, benefits and services that may be of interest to you. The following communications are used by the practice:

1. Postcards mailed to you at the address provided by you.
2. Telephoning your home and leaving a message on your answering machine or with the individual answering the phone.
3. We will remember you on your birthday with a customary card.
4. Newsletters, with health information we believe to be valuable to you, will be sent periodically.
5. Ordinary practice related information may be communicated to you by any physical or electronic method that may be available and deemed reasonable and appropriate by the compliance officer.

PRIVACY OFFICER – GEORGE TOMES, DC

Dr. Tomes is responsible for all privacy issues and can be contacted by phone or mail at our office. Dr. Tomes will maintain HIPAA privacy compliance and may change the terms of this privacy policy without notice to best preserve the privacy of your information. You are entitled to a copy of this policy and any future changes that may affect your information.

AGREEMENT AND SIGNATURE AS OF ______/______/______ By signing below I acknowledge that I understand and agree to the above and have indicated any restrictions I wish to apply to my records on the reverse side of this page.

Patients Name:______________________________
Signature of Patient:________________________________
Parent or Guardians Name: ______________________
Signature of Parent or Guardian: __________________

Name:____Date:____________________________

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____________________________ _______________________________ ______________
Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _________________________ being the parent or legal guardian of _______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _______________________________________

____ ______________________
Signature Date

Name:____Date:___________________________

INFORMED CONSENT FOR NUTRITIONAL CONSULTING

This is not medical treatment. This is only nutritional support.

DO NOT STOP TAKING ANY MEDICATIONS WITHOUT SEEKING THE ADVICE OF A MEDICAL DOCTOR.

Discontinuing medical treatment without the advice of a medical doctor could seriously damage your health or cause death.

Signature____ Date______________________