APPLICATION FOR CARE

Welcome to our office. Please print and thoroughly complete <u>all</u> questions and return to front desk. Please know all information is kept confidential.Thank you.

Name: _____Today's Date: _____

Address: _____City/State/Zip: _____

E-Mail: _____

Phone: (H) _____ (W) _____(C): _____

Marital status: S M W D Birth date: ____/____/____ Age: _____

Occupation:_____ Employer/Company:_____

Who may we thank for referring you? _____

Spouse's name: _____Occupation: _____

Children's names & ages: _____

Past DC (Doctor of Chiropractic):_____Last DCvisit: _____

Primary Care Providers Name (MD / DO):_____Town_____
Date of last visit: _____ Purpose of visit:_____

Please list any specialists seen (Drs. Name):
Name: _____Last visit:_____Purpose:_____
Name: _____Last visit_____Purpose:_____

Hobbies/activities:
_____

Hours of exercise per week: _____ what do you do? _____

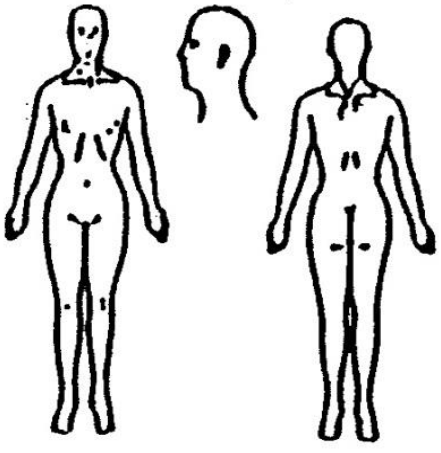
Hours of work per week: _____ Do you smoke?_____ If yes,PPD_____ How many years?_____

Please list all current health problems, issues, and challenges

1. _____2. _____ 3. _____

4. _____5. _____ 6. _____

<u>Please mark problem areas>>></u>



Please list any auto accidents / work/ sport injuries and date?

_____

_____

Is your current condition(s) due to any or auto accident? YES NO IF YES, STOP *NOTIFY STAFF*

Do you have an attorney? If yes, please provide Name, Address and Phone # _____

_____

Please note when was the last time you experienced same or similar symptoms or conditions as now?

_____

Check off family members with same or similar health problems:
___grandparents (GM/ GF), ___father, ___mother, ___brother, ___sister ___children
Explain:_____

Spinal X-Rays, MRI, or CT: Note date, facility, body part, and result: _____

_____

_____

Please list any additional medical procedures or surgery you have had. Note when and for what reason.

_____

_____

Have you ever been diagnosed or treated for cancer, heart disease, or any other chronic disease? No Yes
If yes,please explain:

_____

Do you know what a "Spinal Subluxation" is? No If yes, please describe

_____

Do you have or ever been shown any daily "Spinal Hygiene"program to do at home, that you presently practice? No Yes
If Yes, please explain:_____

(Women) Is there any possibility that you are pregnant? _____ Last cycle date_____ Initial_____

How will you be paying for today's visit? ___ Cash ___Check ___Debit card ___Credit card

The above information is true and accurate to the best of my knowledge. My reason for consultation with Dr. Gurman is for evaluation of my physical health and the potential for improvement. I understand that I am personally financially responsible for all services I receive.

_____ _____ _____

Patient or Guardian Signature **Date** **Staff (initial)**

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program
CMS requires providers to report both race and ethnicity

- First Name:_____ **Last Name**:_____

- Email address: _____@_____ **DOB:** __/__/____

- Preferred Language: _____ **Gender (Circle one):** Male / Female

- Smoking Status (Check one):

___Every Day Smoker
___Occasional Smoker
___Former Smoker
___Never Smoked

-Height: ____' ____'' **Weight**:_____ **Blood Pressure**:_____ /_____

- Race (Check one):

___American Indian or Alaska Native
___Asian
___Black or African American
___White (Caucasian)
___Native Hawaiian or Pacific Islander
___Other
___I Decline to Answer

-Ethnicity (Check one):

___Hispanic or Latino
___Not Hispanic or Latino
___I Decline to Answer

- Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

- Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

WFC NOTICE OF PRIVACY PRACTICES

By my signature or guardian signature I have read the Privacy Notice and authorization for appointment reminders, scheduling, and contact and understand my rights contained in the notice.

_____

Patient Name (please print)

_____ _____

Patient/Guardian Signature Date

_____

Authorized Westwood Family Chiropractic,LLC Staff Signature