

PATIENT INFORMATION

Date _____
Patient Name _____
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ DOB _____
SSN _____
Home# _____ Work# _____
Cell # _____

Married Widowed Single Separated Divorced

Minor Partnered for _____ years

Race: Asian Black Hispanic Indian White

Other _____

Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Spouse's Name _____

DOB _____ SSN _____

Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____ Phone # _____

Who can we thank for referring you?

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Member ID _____ Group# _____

Is patient covered by additional insurance? Yes No

Ins. Co. _____

Member ID _____ Group # _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Type of accident Auto Work Home

Other _____

To who have you made a report of your accident?

Auto Ins. Employer Worker Comp Other

Date of Injury _____

Attorney Name _____

MRI/X-RAYS/CT SCANS

Have you had any imaging done? Yes No

If so, when and where? _____

Have you seen anyone else for this condition? Yes

No If so, whom and when? _____

COMMUNICATION

Email Address _____

Would you like to receive our Newsletter? Yes No

How would you like to receive appointment reminders?

Phone Call Text Message Email

Patient Name _____ ID# _____ Date _____

PATIENT CONDITION

Reason for Visit _____

When did you first notice the symptom(s)? _____

Is this condition getting progressively worse? Yes No

Where specifically is the problem(s) located? _____

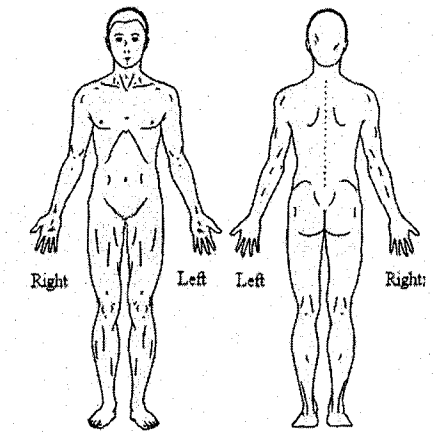
Which activities are difficult to perform? Sitting Standing Walking

Bending Lying down Other _____

Type of pain: Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Cramps Stiffness Swelling

Other _____



Please mark all problem areas.

Rate the severity of your pain. (1-mild to 10-severe). 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? _____

Name and address of other doctor(s) who have treated you for your condition:

Health History

Indicate any of the conditions you currently have or had in the past

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis | _____ |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Cataracts | | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis | |

Authorization for Release/Request of Medical Information

To Whom It May Concern:

I hereby authorize the office of Wendy Cunningham, D.C. to request any medical records, x-rays, emergency reports, physician's reports, police reports, and/or other pertinent information pertaining to my case as necessary. I also hereby authorize the office of Wendy Cunningham, D.C. to release or furnish to any requesting hospital, physician, medical attendant, insurance company, or attorney, any and all medical information, including x-rays, pertaining to my case.

_____ (Patient's initials)

Informed Consent to Chiropractic or Massage Treatment

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me or on the patient named below, for whom I am legally responsible, by Wendy Cunningham, D.C.

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect Wendy Cunningham, D.C. to be able to anticipate and explain all of the risks and complications and wish to rely on the doctor to exercise judgment to act in my best interest during the course of treatment.

I have read and understand the above consent form and understand the risks of the recommended treatment. I understand and consent to the treatment being delivered by Dr. Wendy Cunningham. No guarantee or assurance of results has been made to me. _____ (Patient's Initials)

I hereby certify that I have read and understand the contents of this form, and I have signed this document knowingly, freely and voluntarily. Moreover, I certify and state that I have received no promised assurances or guarantees from anyone as to the results that may be obtained by any treatment or services.

Patient/Parent/Guardian Signature

Date

Witness

Date

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

NAME OF INSURANCE COMPANY (IES)

and assign directly to Dr. Wendy Cunningham and/or Hayden Health and Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Wendy Cunningham, and/or Hayden Health and Wellness, may use my health care information and may disclose such information to the above-named insurance company (or companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____

Print Patient Name

Have received a copy of **Hayden Health and Wellness'** Notice of Privacy Practices.

Patient Signature

Date

For Minors:

Patient Name

DOB

Signature Guardian

Date



HAYDEN HEALTH & WELLNESS

Appointment Policies

Hayden Health and Wellness respectfully requests the courtesy of a 24-hour cancellation notice of any of your appointments. Further, excessive cancellations and rescheduling of appointments will need to be addressed. Last minute cancellations and no shows will result in a \$30.00 fee.

We do understand that emergencies and illnesses do occur---if you are sick, or have children that are ill and need you at home, within 24 hours of your appointment---please cancel your appointment. There is no charge for these types of cancellations.

Your health is our top priority, and we appreciate your loyalty to us. We set these appointment times aside specifically for your care. We in turn hope you appreciate and value our time and services by keeping your appointment. Our schedule often does not allow for extended appointment times if you are late we may need to reschedule.

Thank you for your understanding. We appreciate your thoughtfulness and commitment in this matter.

I have read and understand the above appointment policies.

Patients' signature (Parent/Guardian if a minor)

Print Name

Date