EPIC WELLNESS
LEADER IN SPORTS CHIROPRACTIC

PATIENT INITIAL PAPERWORK

NAME: _____ PREFERRED PRONOUNS: _____

AGE: _____ BIRTHDATE: _____ SEX: Male / Female

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ CELL PHONE: _____

REFERRED BY:
□ Family / Friend □ Company □ Online Search □ Insurance Provider □ Other:_____

INSURANCE: I clearly understand that all insurance coverage, whether accident, work-related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and I am ultimately responsible for any unpaid balances.

Insurance Company: _____

ID / Subscriber #:_____ Group #:_____

Patient Signature:_____ Date: _____

CONSENT FOR CARE: I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: _____ Date:_____

HIPPA NOTICE: I acknowledge and agree to the following:
1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): _____

Patient Signature: _____ Date:_____

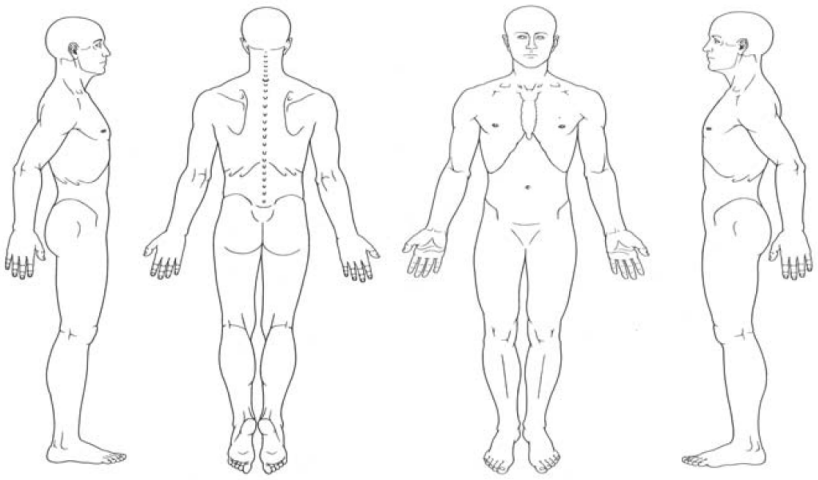
How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Shooting
- ❑ Dull ache
- ❑ Burning
- ❑ Numb
- ❑ Tingling
- ❑ Dizziness
- ❑ Headaches/ Migraine
- ❑ TMJ pain

Indicate where you have pain or other symptoms



What activities make your symptoms worse: _____

What activities make your symptoms better: _____

List all surgeries: _____

List all medications: _____

List any other health conditions: _____

Are you or is there a possibility that you could be pregnant? (Circle One) Yes / No

PREFERENCES:

PRESSURE: (select all that apply):

- ❑ Light
- ❑ Light to Moderate
- ❑ Moderate
- ❑ Moderate to Deep Trigger Point Work

GOALS OF CARE: (select all that apply):

- ❑ Pain Relief
- ❑ Improved Athletic Performance
- ❑ Maintenance

AREAS TO AVOID: _____

ADDITIONAL COMMENTS: Please tell the therapist any additional details.

_____

_____

_____

Patient Signature _____ *Date:* _____