Today's Date: / /

Patient's Full Name:

What You Prefer To Be Called:

O Male O Female

Birthdate: / / Age:

Phone #:

Alternate #:

Mailing Address:

City State Zip

Email Address:

Referred To Our Office By:

Employer:

Occupation:

How Long?

O Minor O Single O Married O Divorced

O Separated O Widowed

Spouses Name:

Do you have children? How Many?

Health History:

Are you taking any of the following medications?

O Nerve Pills O Pain Killers O Tranquilizers

O Muscle Relaxers O Blood Thinners O Insulin

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack/Stroke
Y N Shingles
Y N Ulcers/Colitis
Y N Alcohol/Drug Abuse
Y N Cancer/Chemo
Y N Psychiatric Problems
Y N Fainting/Seizures/Epilepsy
Y N Heart Murmurs
Y N Sinus Problems
Y N Lower Back Problems
Y N Emphysema/Asthma

Y N Artificial Valves
Y N Heart Surg./Pacemaker
Y N Severe/Frequent Headaches
Y N Difficulty Breathing
Y N HIV+/AIDS/ARC
Y N Hepatitis
Y N Anemia/Diabetes
Y N Arthritis
Y N High/Low Blood Pressure
Y N Artificial Bones/Joints
Y N Tuberculosis

Emergency Contact Name:

Relation:

Phone #:

Reason For Visit:

O Emergency O New Injury O Old Injury
O Chronic Pain O Wellness O Pregnancy

Are you in pain? Scale 1-10?

Did your injury occur during:

O Auto Accident O Work O Sports/Play
O Routine/Household Activity

Date your injury occurred: / /

Is your condition getting worse? O Y O N

Is it: O Constant O Comes and goes

Is your condition interfering with your?:
O Work O Sleep O Daily Routine

Has something similar happened in the past?

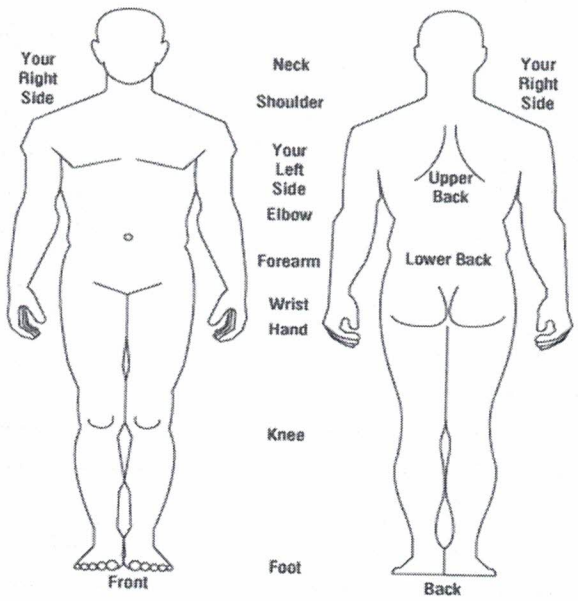
If so, Explain:

Have you been treated by a Medical Physician for this condition? O Y O N

If so, where?

Have you ever been treated by a Chiropractor?

O Y O N Clinic or Doctor's name?



Please list any surgeries with dates and/or other serious medical conditions not listed previously:

List any past serious accidents with dates:

Please list anything you may be allergic to:

Do you take supplements or Vitamins? O Y O N

Do you exercise? O Y O N

How many hours per week?

Do you smoke? O Y O N

If so, how much? How long?

Are you dieting? O Y O N Since: / /

Are you taking birth control? O Y O N

Are you nursing? O Y O N

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- **Our policy requires payment in full for all services rendered at the time of visit.**

- I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:

Date: / /

O Adult Patient O Parent or Guardian O Spouse

WELLS CHIROPRACTIC

1001-G East WT Harris Blvd.
Charlotte, NC 28213

Consent For Treatment and Authorization to Perform X-Rays

I have been informed that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize any radiographic examination necessary to diagnose and administer whatever treatment necessary to treat my present problem.

Signed: _____
Date: _____

Witness: _____
Date: _____

To the best of my knowledge, I am NOT pregnant, and the doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____
Date: _____

Notice of Privacy Practices

This document is to certify that I have received the Notice of Privacy Practices document and will read it carefully. In addition, I have been informed that if I have any questions that I may contact:

Wells Chiropractic
704-547-9494
1001-G East WT Harris Blvd.
Charlotte NC 28213

Signature of Patient:

_____

Signature of Witness:

_____

Date: _____

List below the person/people that you wish to have access to your records:

THE NATURE AND PURPOSE OF CHIROPRACTIC

- Adjustments are made by chiropractors in order to correct spinal extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition is one where one or more vertebra in the spine is misaligned sufficiently to cause interference and/or irritation to the nervous system. The primary goal in Chiropractic health care is the removal of nerve interference caused by subluxation.
- The chiropractic adjustment is the application of precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which chiropractic adjustments are delivered. Chiropractic adjustments are typically delivered by hand, but some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol.
- I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risk of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probably effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the result of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE WELLS CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATE THIS ___ DAY OF ___ 20___,
CHARLOTTE, NORTH CAROLINA

Patient Signature: _____

Dr. H. Lee Ferrell Signature: _____

Parental Consent for Minor Patient
Patient Name: _____
Patient Age: _____ DOB: _____
Printed name of person authorized to sign for Patient:
_____

Signature: _____
Relationship to Patient: _____

Accident Questionnaire

Date of accident: / / City/State it occurred in:

These questions are regarding the **vehicle you were in** during the accident:

Driver of the car?

Who owns the car? (If not the driver)

Insurance company:

Policy Number:

Claim Number:

Adjusters Name: Adjusters Phone #:

Adjusters Email: Adjusters Fax #:

Where were you seated inside of the vehicle?

Approximate $ amount of damage done to the vehicle?

These questions are regarding the **vehicle that hit you**:

Driver of the car?

Who owns the car? (If not the driver)

Insurance company:

Policy Number:

Claim Number:

Adjusters Name: Adjusters Phone #:

Adjusters Email: Adjusters Fax #:

Most of this information is provided in the accident report. If you have a copy that you can provide to us, we will only need the Claim and Adjusters information from you. Please bring it to the front desk or email the accident report to info@wellschiro.com

What area of your vehicle was struck?
O Front O Rear O Driver's Side O Passenger Side

In your own words, please describe the accident:

Did any parts of your body/head hit any part of the vehicle? If so, explain:

Did you see the accident coming? O Y O N If yes, did you brace for impact? O Y O N

Were you wearing a seatbelt? O Y O N | Does the vehicle have a headrest? O Y O N

Was your car moving at the time of the accident? O Y O N If yes, how fast were you going? MPH

How fast would you estimate the other vehicle was travelling? MPH

Were you able to get out of the car and walk unaided afterwards? O Y O N | Please describe your injuries that are a result of the accident as detailed as possible:

Accident Questionnaire

Please check any symptoms you have experienced since the accident:

O Headache O Anxiety O Tension O Irritability O Fatigue O Dizziness O Fainting O Cold Sweats
O Sleeping Problems O Numbness in toes/fingers O Loss of smell/taste O Loss of memory
O Pain behind your eyes O Shortness of breath O Sensitivity to light O Depression O Cold hands/feet
O Ringing/Buzzing in your ears O Nervousness O Mid back pain O Low back pain O Neck pain
O Cold sweats O Facial Pain O Chest Pain Loss of balance O Diarrhea or constipation O Jaw clicking

Occupation: Employer:

Have you missed time from work? O Y O N | If yes, what dates?

Did you seek medical help immediately after the accident? O Y O N

Were you examined? O Y O N | Were x-rays taken? O Y O N | Did you receive treatment? O Y O N

If yes, what kind?

Do you have an attorney? O Y O N | If yes, who?