The doctors and staff are happy to welcome you to Health Plus!

We want you to feel comfortable as you become a new patient in our office.

Please read this step by step outline of

"What to expect."

1. The purpose of today's visit is to determine the cause of your health problem. This first step requires everyone to fill out this ***Personal Health History Questionnaire***.

2. When you complete this form, you will ***meet privately with the Doctor of Chiropractic*** to discuss your health problems and any concerns you may have.

3. An appropriate ***examination and evaluation*** will follow including tests necessary to determine the precise cause of your health problems.

4. You will be ***scheduled for a Report of Findings*** to go over the results of this first visit along with any recommendations for treatment.

5. On your ***Report of Findings visit*** you will be given:
   - A thorough explanation of your problem.
   - Recommendations for treatment type, treatment schedule, and anticipated length of care necessary to attain the best possible results.
   - The cost of your treatment will be given to you at that time including any applicable insurance coverage and the amounts that you will need to pay.

6. Our ***office procedures, payment options, and your treatment schedule*** will be explained to you.
   - If we can accept you as a patient, chiropractic care will begin right at this point and we will follow your treatment schedule so that a maximum correction for your condition can be obtained.

7. All along the way of your treatment schedule, your ***improvements will be monitored*** so that we make sure that we get the best results possible.

8. After maximum correction has been attained, ***recommendations will be made*** for future care to help prevent future problems and maintain good health.

THE POWER THAT MADE THE BODY HEALS THE BODY
SO WE CAN GET WELL AND STAY WELL

DR. JOE ESPOSITO, DC, BS,
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LAST NAME: _____
ROF: DATE: ____ / ____ / ____ (MM / DD / YYYY)

PERSONAL HEALTH HISTORY

Clear All Fields

CONFIDENTIAL PATIENT HEALTH RECORD

TODAY'S DATE: ____ / ____ / ____ Today's Date (MM/DD/YYYY)

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

DAY PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____

SEX: ☐ MALE ☐ FEMALE ☐ _____

E-MAIL: _____

WORK PHONE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

TITLE: ☐ MR. ☐ MS. ☐ MRS. ☐ MISS. ☐ DR. ☐ REV. ☐ HON.

WORK STATUS: ☐ UNEMPLOYED ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ SELF EMPLOYED ☐ DISABLED - NOT WORKING

OCCUPATION: _____

EMPLOYER: _____

BUSINESS PHONE: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

SPOUSE'S NAME: _____

SPOUSE'S HEALTH INSURANCE CO NO: _____

SPOUSE'S SSN NO: _____

SPOUSE'S DOB: _____

SPOUSE'S EMPLOYER: _____

BUSINESS PHONE: _____

TYPE OF WORK: _____

NAME & AGE OF CHILDREN: _____

REFERRED TO THIS OFFICE BY: _____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

WHO IS RESPONSIBLE FOR YOUR BILL? YOU AND: ..... ☐ SPOUSE ☐ WORKMAN'S COMP. ☐ AUTO INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ PRIVATE HEALTH INSURANCE

NAME OF INSURANCE COMPANY: _____ HEALTH INSURANCE CARD #: _____
PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD SO THAT WE CAN MAKE A COPY

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE ? ..... ☐ YES ☐ NO IF SO .....WHO ? DR. _____

RESULTS ? ☐ GOOD ☐ FAIR ☐ POOR COMMENTS: _____

IF YES, WHEN WAS THE LAST TIME YOU SAW A CHIROPRACTOR ? _____ (MM / DD / YYYY) _____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION ? ..... ☐ YES ☐ NO IF SO ..... WHO ? DR. _____

PLEASE SUPPLY ANY OF YOUR HEALTH RECORDS THAT YOU HAVE AVAILABLE. PLEASE LIST YOUR PRIMARY CARE PHYSICIAN: _____

HAVE YOU BEEN IN A CAR ACCIDENT ? ..... ☐ YES ☐ NO IF YES, WHEN WAS THE ACCIDENT YOU WERE IN ? _____

OFFICE USE ONLY:

OFFICE LOCATION:
☐ MARIETTA
☐ DULUTH
☐ STOCKBRIDGE

ACCT ID: _____

SCAN DATE: ____ / ____ / ____ (MM / DD / YYYY)

CASE ID: _____ INT: _____ COMPLETED DATE: ____ / ____ / ____ (MM / DD / YYYY)

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PATIENT'S FULL NAME: _____ DATE: ____ / ____ / ____ (MM / DD / YYYY)

1. IS THIS CONDITION: ☐ JOB RELATED ☐ AUTO ACCIDENT ☐ HOME INJURY ☐ FALL ☐ OTHER: _____

IF ACCIDENT RELATED - DATE: _____ (MM / DD / YYYY) TIME OF ACCIDENT: _____ ☐ AM ☐ PM

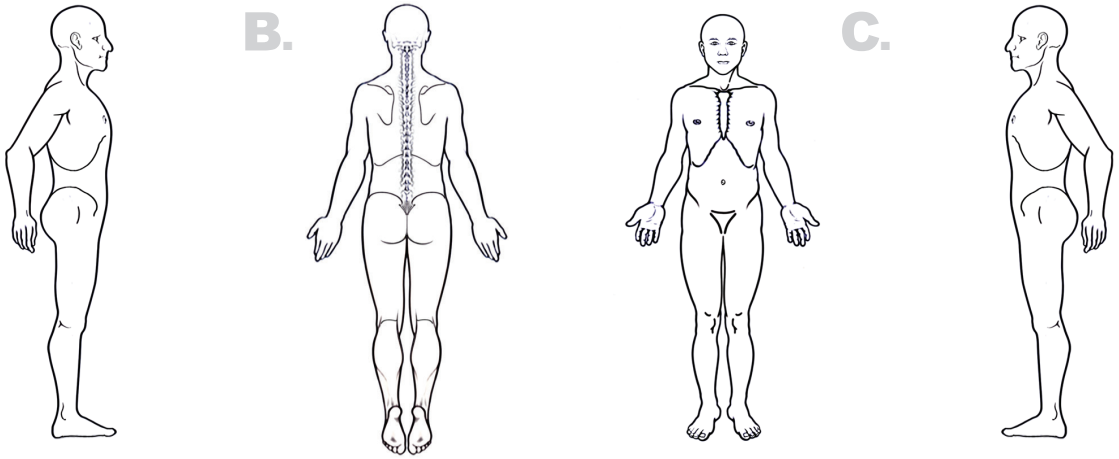
HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER ? ☐ YES ☐ NO ☐ N/A

DRUGS YOU NOW TAKE: ☐ NERVE PILLS ☐ PAIN KILLERS / MUSCLE RELAXERS
☐ BLOOD PRESSURE MEDICINE ☐ INSULIN
☐ OTHER _____

DO YOU USE OR WEAR OTHER ASSIST DEVICES ?
DO YOU WEAR A SHOE LIFT OR ORTHOTIC: ☐ YES ☐ NO
☐ OTHER _____

2. INDICATE ON THE DRAWING BELOW WHERE YOU HAVE PAIN / SYMPTOMS:

A. B. C. D.



3. HOW OFTEN DO YOU EXPERIENCE SYMPTOMS ?

PLEASE - IF NEEDED - WRITE ADDITIONAL COMMENTS ON PAGE 4 OF THIS FORM .

☐ CONSTANTLY (76-100% OF THE TIME)
☐ FREQUENTLY (51-75% OF THE TIME)
☐ OCCASIONALLY (26-50% OF THE TIME)
☐ INTERMITTENTLY (1-25% OF THE TIME)

4. HOW WOULD YOU DESCRIBE THE TYPE OF PAIN ?

☐ ACHY ☐ DULL ☐ SHARP ☐ BURNING ☐ SHOOTING
☐ DIFFUSE ☐ STIFF ☐ NUMB ☐ TINGLY
☐ SHARP WITH MOTION ☐ SHOOTING WITH MOTION ☐ STABBING WITH MOTION ☐ ELECTRIC LIKE WITH MOTION
☐ OTHER: _____

PLEASE WRITE ADDITIONAL COMMENTS ON PAGE 4 OF THIS FORM.

5. HOW ARE YOUR SYMPTOMS CHANGING WITH TIME ?

☐ STAYING THE SAME ☐ GETTING BETTER ☐ GETTING WORSE _____

6. USING THE BELOW SCALE FROM 0-10 (10 BEING THE WORST) HOW WOULD YOU RATE YOUR PROBLEM ?

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ (PLEASE CIRCLE)

7. HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR WORK ?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

8. HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR SOCIAL ACTIVITIES ?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

9. WHO ELSE HAVE YOU SEEN FOR YOUR PROBLEM ?

☐ CHIROPRACTOR ☐ PHYSICAL THERAPIST ☐ MASSAGE THERAPIST ☐ PRIMARY CARE PHYSICIAN ☐ NO ONE
☐ ER PHYSICIAN ☐ NEUROLOGIST ☐ ORTHOPEDIST ☐ SPECIALTY CLINIC OR HOSPITAL
☐ OTHER: _____

10. HOW LONG HAVE YOU HAD THIS PROBLEM ? _____ ☐ DAYS ☐ MONTHS ☐ YEARS

11. HOW DO YOU THINK YOUR PROBLEM BEGAN ? _____

12. DO YOU CONSIDER THIS PROBLEM TO BE SEVERE ? ☐ YES ☐ YES, AT TIMES ☐ NO

13. WHAT AGGRAVATES YOUR PROBLEM ? _____

14. WHAT CONCERNS YOU THE MOST ABOUT YOUR PROBLEM; WHAT DOES IT PREVENT YOU FROM DOING ?

PLEASE WRITE ADDITIONAL COMMENTS ON PAGE 4 OF THIS FORM

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PATIENT'S FULL NAME: _____ DATE: ____ / ____ / ____ (MM / DD / YYYY)

15. WHAT IS YOUR: HEIGHT: _____ WEIGHT: _____ WAIST: _____

16. HOW WOULD YOU RATE YOUR OVERALL HEALTH ?

☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

17. WHAT TYPE OF EXERCISE DO YOU DO?

☐ STRENUOUS ☐ MODERATE ☐ LIGHT ☐ NONE

18. INDICATE IF YOU HAVE ANY IMMEDIATE FAMILY MEMBERS WITH ANY OF THE FOLLOWING:

☐ RHEUMATOID ARTHRITIS ☐ DIABETES ☐ LUPUS ☐ HEART PROBLEMS ☐ CANCER ☐ ALS

19. FOR EACH OF THE CONDITIONS LISTED BELOW, PLACE A CHECK IN THE "*PAST*" COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST: IF YOU HAVE PRESENTLY HAVE A CONDITION LISTED BELOW, PLACE A CHECK IN THE "*PRESENT*" COLUMN:

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	HEADACHES	☐	☐	HIGH BLOOD PRESSURE	☐	☐	DIABETES
☐	☐	NECK PAIN	☐	☐	HEART ATTACK	☐	☐	EXCESSIVE THIRST
☐	☐	UPPER BACK PAIN	☐	☐	CHEST PAIN	☐	☐	FREQUENT URINATION
☐	☐	MID BACK PAIN	☐	☐	STROKE	☐	☐	SMOKING / TOBACCO USE
☐	☐	LOW BACK PAIN	☐	☐	ANGINA	☐	☐	DRUG / ALCOHOL DEPENDENCE
☐	☐	SHOULDER PAIN	☐	☐	KIDNEY STONES	☐	☐	ALLERGIES
☐	☐	ELBOW / UPPER ARM PAIN	☐	☐	KIDNEY DISORDERS	☐	☐	DEPRESSION
☐	☐	WRIST PAIN	☐	☐	BLADDER INFECTION	☐	☐	SYSTEMIC LUPUS
☐	☐	HAND PAIN	☐	☐	PAINFUL URINATION	☐	☐	EPILEPSY
☐	☐	HIP PAIN	☐	☐	LOSS OF BLADDER CONTROL	☐	☐	DERMATITIS / ECZEMA / RASH
☐	☐	UPPER LEG PAIN	☐	☐	PROSTATE PROBLEMS	☐	☐	HIV / AIDS
☐	☐	KNEE PAIN	☐	☐	ABNORMAL WEIGHT GAIN / LOSS	☐	☐	ACID REFLUX
☐	☐	ANKLE / FOOT PAIN	☐	☐	LOSS OF APPETITE	☐	☐	HEART BURN
☐	☐	JAW PAIN	☐	☐	ABDOMINAL PAIN	☐	☐	GAS
☐	☐	JOINT / PAIN STIFFNESS	☐	☐	DIGESTIVE PROBLEMS	☐	☐	BLOATING
☐	☐	ARTHRITIS	☐	☐	ULCER	☐	☐	DIARRHEA
☐	☐	RHEUMATOID ARTHRITIS	☐	☐	HEPATITIS	☐	☐	CONSTIPATION
☐	☐	CANCER	☐	☐	LIVER / GALL BLADDER DISORDER	**FOR FEMALES ONLY**		
☐	☐	TUMOR	☐	☐	GENERAL FATIGUE	☐	☐	BIRTH CONTROL PILLS
☐	☐	ASTHMA	☐	☐	MUSCULAR COORDINATION PROBLEM	☐	☐	HORMONAL REPLACEMENT
☐	☐	CHRONIC SINUSITIS	☐	☐	VISUAL DISTURBANCES	☐	☐	PREGNANCY
☐	☐	ERECTILE DYSFUNCTION	☐	☐	DIZZINESS			
☐	☐	OTHER: _____						

PLEASE WRITE ADDITIONAL COMMENTS ON PAGE 4 OF THIS FORM PLEASE INCLUDE QUESTION NUMBER(S) WITH YOUR COMMENTS

20. LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING: ☐ PAIN KILLERS/MUSCLE RELAXERS ☐ BLOOD PRESSURE MEDICATION ☐ NERVE PILLS _____

21. LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

22. LIST ALL SURGICAL PROCEDURES YOU HAVE HAD:

23. WHAT ACTIVITIES DO YOU DO AT WORK?

☐ **SIT**	☐ MOST OF THE DAY	☐ HALF THE DAY	☐ A LITTLE OF THE DAY
☐ **STAND**	☐ MOST OF THE DAY	☐ HALF THE DAY	☐ A LITTLE OF THE DAY
☐ **COMPUTER WORK**	☐ MOST OF THE DAY	☐ HALF THE DAY	☐ A LITTLE OF THE DAY
☐ **ON THE PHONE**	☐ MOST OF THE DAY	☐ HALF THE DAY	☐ A LITTLE OF THE DAY

24. WHAT ACTIVITIES DO YOU DO OUTSIDE OF WORK ? _____

25. HAVE YOU EVER BEEN HOSPITALIZED? ☐ NO ☐ YES

IF YES, WHY: _____

26. HAVE YOU HAD SIGNIFICANT PAST TRAUMA? ☐ NO ☐ YES

IF YES, DESCRIBE: _____

27. PLEASE NOTE ANYTHING ELSE OR OTHER PROBLEMS YOU ARE HAVING THAT ARE PERTINENT TO YOUR VISIT TODAY:

☐ PLACE A CHECK MARK IN THE BOX IF YOU ADDED COMMENTS ON PAGE 4 FOR ANY OF THE QUESTIONS 1 THROUGH 27.

Patient Signature: _____ Date: ____ / ____ / ____ (MM/DD/YYYY)

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PATIENT'S FULL NAME: _____ DATE: ____ / ____ / ____ (MM / DD / YYYY)

ADDITIONAL COMMENTS: FROM *QUESTIONS 1 THROUGH 27 ON PAGES 2 & 3* - PLEASE INCLUDE THE *QUESTION NUMBER(S)* WHEN WRITING *ADDITIONAL COMMENTS* HERE.

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☐ CHECK THE BOX TO THE LEFT AND PROVIDE YOUR EMAIL ADDRESS IF YOU WOULD LIKE TO RECEIVE DR. JOE'S HEALTH WELLNESS NEWSLETTER IN YOUR IN BOX. E-MAIL: _____

PATIENT'S FULL NAME: _____ DATE: ____ / ____ / ____ (MM / DD / YYYY)

CONSENT FOR TREATMENT

I, the undersigned, herby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature: _____ Date: ____ / ____ / ____

Witness: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature: _____ Date: ____ / ____ / ____

Witness: _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance Company /Insurance Administrator to pay by check, and for it to be mailed directly to Health Plus Wellness the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature: _____ Date: ____ / ____ / ____

Witness: _____

ACKNOWLEDGE AND ACCEPT HIPPA NOTICE (LOCATED ONLINE ON OUR WEBSITE)

I hereby authorize and accept Health Plus Wellness Center's HIPPA notice. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and a copy of this notice and acknowledge I am able to review it online at any time.

Patient's Signature: _____ Date: ____ / ____ / ____

Witness: _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____ .

Relationship of child: _____

Child's name: _____

Patient's or Guardian Signature: _____ Date: ____ / ____ / ____

Witness: _____