MANNING
WELLNESS CLINIC
CHIROPRACTIC • MASSAGE THERAPY • ACUPUNCTURE

# Welcome to Manning Wellness Clinic

Thank you for choosing our office for your healthcare. We are committed to providing the highest quality of corrective and wellness chiropractic care and acupuncture available so that you and your family can enjoy an active, healthy life. We will work together to help you reach your health and wellness goals.

If you ever have any questions regarding your care, please do not hesitate to ask. We look forward to a long, healthy, communicative relationship with you and your family.

## Financial Policy

We are committed to providing you the best healthcare possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time service is rendered. Discounted prepaid care packages are available for purchase. Inquire at the front desk for details.

Health Insurance: We do not file directly with any insurance companies. We can provide you with a itemized statement to submit to your insurance company for direct reimbursement.

Third party auto claims will be considered on a case by case basis.

I have read and I understand the above policies.

| Print patient's name | Patient Signature | Date |
|---|---|---|

**Manning Wellness Clinic**
2702 McKinney Ave. Suite 202
Dallas, TX 75204
(214) 720-2225

**Date** _____ **Social Security #** _____-_____-_____

**Name** _____ **Date of Birth** _____**Age** _____ **M/F**

**Address** _____**City** _____ **State** _____ **Zip** _____

**Phone: H(___)**_____**W(___)**_____**C/P(___)**_____

**Email:** _____ **Occupation:** _____

**Employer (name/address)**_____

**Marital Status: S M D W Spouse:** _____

**Spouse occupation:** _____

**Children: Y/N Names and Ages:** _____

**Have you ever received chiropractic care? Y/N (when/where)?** _____

**Have you ever received a massage? Y/N How often:** _____

**Have you been treated by an acupuncturist? (when/where)?** _____

**Emergency Contact: (Name)** _____

**Relationship:** _____ **Phone:** _____

**How did you find out about our clinic?** _____

## About Your Health

The human body is designed to be healthy. Unfortunately, for most of us, that is not always the case. Throughout life, events occur which damage and interfere with our good health.

Beginning with your examination and throughout your lifetime of care, we will work together to remove these interferences and allow you to live the healthy, active life you deserve. This case history will reveal the layers of damage that have resulted in your current state of health.

## Loss of Wellness

| Yes | No | **1. Was your birth traumatic?** | If Yes, explain | Dr's notes |
|---|---|---|---|---|
| ❑ | ❑ | Was the delivery long? Difficult? | _____ | _____ |
| ❑ | ❑ | Caesarian/ Breach/ cephalic? | _____ | _____ |

**2. Growth and Development**

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | Did you suffer from ear infections? | _____ | _____ |
| ❑ | ❑ | Did you suffer from colic? | _____ | _____ |
| ❑ | ❑ | Did you ever fall out of bed? | _____ | _____ |
| ❑ | ❑ | Childhood: Sicknesses? Accidents? Surgery? | _____ | _____ |
| | | Please list: _____ | | |
| ❑ | ❑ | Did you fall down stairs? | _____ | _____ |
| ❑ | ❑ | Other physical traumas? What? When? | _____ | _____ |
| ❑ | ❑ | Were you involved in sports? Y/N Type: | _____ | _____ |

**3. Current Health**

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | Have you been in **any** accidents? | _____ | _____ |
| ❑ | ❑ | Surgeries? (list type and dates) | _____ | _____ |
| ❑ | ❑ | Teeth, eye, hearing problems? | _____ | _____ |
| ❑ | ❑ | Do you exercise regularly? How often? | _____ | _____ |
| ❑ | ❑ | Do you suffer physical and/or mental stress? Y/N Type: | _____ | |
| ❑ | ❑ | What are your hobbies? | _____ | |
| ❑ | ❑ | Hours per day spent on cell phone/tablet: | _____ | _____ |
| ❑ | ❑ | Have you suffered sports injuries? What/When? | _____ | _____ |
| ❑ | ❑ | Sleep patterns Insomnia? Excessive? Nightmares? | _____ | _____ |
| ❑ | ❑ | Sleeping posture side/stomach/back? | _____ | _____ |
| ❑ | ❑ | Do you feel rested when you wake up in the morning? | _____ | |

**Lifestyle habits**: (How much, if any, do you consume per day?)

Tobacco _____ Tea / Soft drinks _____ Coffee _____ Alcohol _____ Water _____

Are you currently taking any prescription medications: (If yes, please list)

_____

Over the counter: _____

Supplements: _____

**Eating habits**:

Number of servings per day: Fruit _____ Green vegetables ____ Yellow/orange vegetables_____

Fatty or fried foods _____ Processed foods _____

Artificial sweetener (including diet drinks, yogurt, gum, etc) _____

**Family history of:**

| | Heart Disease | | Arthritis | Cancer | Diabetes | Other |
|---|---|---|---|---|---|---|
| | _____ | | | | | |
| Father's side | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Mother's side | ❑ | ❑ | ❑ | ❑ | ❑ | |

**Symptoms and Ill Health (Present State of Health)**

Please list the symptoms you are currently experiencing and the approx date when they began:

1._____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

2._____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

3. _____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

4. _____ ❑Sharp ❑Dull ❑Constant ❑Intermittent

What activities aggravate your symptoms?

_____

What activities lessen your discomfort/pain?

_____

Is condition worse during certain times of day?

_____

Is this condition interfering with Work? _____ Sleep? _____ Daily routine? _____ Other? _____

Is this condition getting progressively worse?

_____

Other doctors seen for this condition?

_____

Any medications or surgeries for this condition?

_____

Are you experiencing other symptoms?

- ❑ Headaches
- ❑ Neck Pain
- ❑ Sleeping Problems
- ❑ Back Pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pains
- ❑ Dizziness
- ❑ Neck stiffness
- ❑ Pins & Needles in Legs
- ❑ Pins & Needles in Arms
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ Shortness of Breath
- ❑ Fatigue
- ❑ Depression
- ❑ Fever
- ❑ Loss of Memory
- ❑ Ringing in Ears
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Diarrhea
- ❑ Cold Feet
- ❑ Cold Hands
- ❑ Stomach Upset
- ❑ Constipation
- ❑ Buzzing in Ears
- ❑ Loss of Balance

Other concerns / Notes: _____

## About Your Care

What results do you hope to achieve from our office?

____ **Relief Care-** Relieve/reduce symptoms and increase comfort.

____ **Corrective Care-** Move beyond pain relief to correct the problem, improve function and allow your body to stabilize.

____ **Wellness Care** – Maintain the care you've received and allow your body to continue to rebuild and become healthier.

## Health Information Practices

**Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**
**If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. This may be via mail, telephone or email.

**May we leave a message either on voicemail or with the person answering the call? Y/N**

**Name of patient:** _____

**Signature of patient or guardian:** _____ **Date:**_____

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various physical therapy modalities, and if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor.

I have had the opportunity to discuss with the doctor and/or other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned chiropractic procedures. I intend this consent form to remain valid throughout my course of treatment in this office.

_____

Doctor's name

_____ _____

Print patient's name Patient Signature (parent/guardian)

_____

Date signed