apple health & wellness

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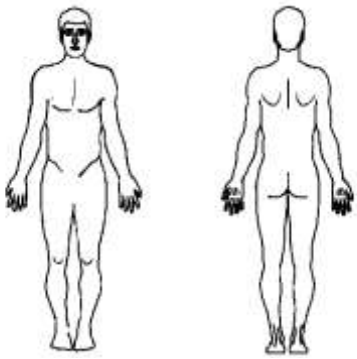
For more info please visit: www.applehealthwellness.com

Patient Name: _____ SS#: _____ Birthdate: _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Home#: _____ Cell#: _____ Email: _____
Occupation: _____ Employer: _____ Work#: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse Name: _____ Spouse's Occupation: _____
Do you have children? ☐ Y ☐ N How many? _____ Preferred Language: ☐ English ☐ Other: _____
Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino
☐ Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ Other Race
Referred By: ☐ Patient/Doctor _____ ☐ Event ☐ Radio/TV ☐ Print Media ☐ Insurance ☐ Internet
Emergency Contact: _____ Emergency Phone Number: _____

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A Date Problem Began: _____

**Mark an X on the picture where you have pain**



Current Complaint (how you feel today): 0 = No Pain 10 = Unbearable Pain
0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? (Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

**In general how is your overall health right now:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Please check all of the following that apply to you:**

☐ Alcohol/Drug Dependence
☐ Recent Fever/Rheumatic Fever
☐ Diabetes
☐ High ☐ Low Blood Pressure
☐ Blood Clots/Stroke (Date): _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting/Concussion
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
☐ Osteoporosis/Arthritis
☐ Epilepsy/Seizures/Convulsions
☐ Other Health Problems (Explain) _____
☐ Prostate Problems
☐ Menstrual Problems/Hormones
☐ Thyroid ☐ Hyper ☐ Hypo
☐ Urinary Problems/Kidneys/Bladder
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Sinus Trouble
☐ Anemia
☐ Back Pain Sciatica
☐ Digestion Problems
☐ Heart
☐ Lungs/Asthma/Bronchial
☐ Shortness of Breath
☐ Fibromyalgia
☐ Gout
☐ Skin
☐ Headaches
☐ Hand or Wrist Pain
☐ HIV/Aids/Blood Infections
☐ Bleeding Disorders
☐ Psychological Problems
☐ Neck Pain or spasms
☐ Neuritis/Numbness/Neuro Disorders
☐ M.S./Muscular dystrophy
☐ Venereal Disease
☐ Liver/Hepatitis/Cirrhosis
☐ Deep Vein Thrombosis
☐ Surgeries: _____

Have you seen a chiropractor this year? ☐ **Yes** ☐ **No** If yes, who? _____ How many visits? _____
Are you currently being treated under home health care? ☐ **Yes** ☐ **No** If yes, who? _____
For Podiatry patients: Shoe Size? _____

**Family Medical Doctor:** _____ Date of Last Visit: _____M _____D _____ Y

**Family History (Mother/Father/Brother/Sister) please check/circle all of the following that apply to you:**

☐ Cancer- M / F / B / S ☐ Heart Disease- M / F / B / S ☐ High Blood Pressure- M / F / B / S ☐ Diabetes- M / F / B / S
☐ Rheumatoid Arthritis/Arthritis- M / F / B / S ☐ Stroke- M / F / B / S ☐ Neurological Disorder- M / F / B / S
☐ Flat Feet- M / F / B / S ☐ Circulation Problems- M / F / B / S

**Smoking Status:** ☐ Current every day smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never Smoked

**Patient Signature:** _____ **Date:** _____

| **ALLERGIES** (please describe reaction such as hives, throat swelling, GI upset) | **Immunization Record** (list date of last vaccination) | |
|---|---|---|
| Allergic to: ☐ Antibiotic ☐ Tape ☐ Betadine (Iodine) ☐ Latex | Flu | Hepatitis |
| ☐ Any Allergies to Medications (please list): | Pneumonia | Tetanus |
| ☐ No Known Allergies | Other: | |

**Medications Currently Taking (including OTC, herbals, patches, nasal sprays, etc.) *If you have a list of your current medication, please give it to the front desk to copy***

| **Medication and Dosage (e.g. diphenhydramine 25mg)** | **Directions (e.g. twice daily, as needed)** | **Started taking (e.g. 2010)** | **Prescribed by: (e.g. Dr. Smith)** |
|---|---|---|---|
| ☐ Not taking any medications | | | |
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## CONSENT TO TREATMENT

I hereby request and consent to the performance of medical, osteopathic, chiropractic, podiatric medicine and surgery, nutritional and other procedures, including but not limited to various modes of physical therapy, massage therapy, joint manipulation, medicine, injections, minor surgical procedures, splinting, casting, wound treatment, and diagnostic tests, on me/child (or the patient named below, for whom I am legally responsible) by the licensed physician(s) and/or other healthcare providers who now or in the future work at the clinic or the office listed above or any other office or clinic. I have had the opportunity to discuss with the physician(s) and/or other healthcare provider(s) and/or with other office or clinic personnel the nature and purpose of the treatments and other procedures. I understand that results are not guaranteed. I understand and am informed that, in the practice of medicine, chiropractic, podiatric medicine and surgery, physical therapy and other applicable methods of treatment, there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations, sprains and infections. I do not expect the physician(s) or other healthcare provider(s) to be able to anticipate and explain all the risks and complications, and I wish to rely upon the physician(s) and/or other healthcare provider(s) to exercise judgment during the course of the procedure which the physician(s) and/or other healthcare provider(s) feel at the time, based upon the facts then know to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____ **Initials**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Apple Health & Wellness Notice of Privacy Practices. This notice describes how Apple Health & Wellness may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. _____ **Initials**

## RIGHT TO SUBMIT BILLING

Apple Health & Wellness will file your claims with your insurance company as a courtesy to you. You will be responsible for your deductible and/or co-payments at the time of treatment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial. As a convenience to our patients, we offer timely and affordable payment plans for each patient that has a care plan for them for their individual condition. This allows patients to receive the care they need while minimizing the stressors of money. Any charges incurred in debt collection will be paid by the patient until all balances are cleared. _____ **Initials**

**IF PATIENT IS A MINOR, YOU MUST COMPLETE THE SECTION BELOW:**

| **Subscriber/Guarantor Name:** | **Social Security Number:** | **Date of Birth:** |
|---|---|---|
| **Subscriber/Guarantor's Address if different from patient:** | **Phone Number if different from patient:** | **Relationship to Patient:** |
| **Employer:** | **Employer Address:** | **Employer Phone Number:** |

## ADDITIONAL INFORMATION

Do you have a living will? ☐ **Yes** ☐ **No**

Patient Name (please print): _____ Date: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

Guardian's Signature (if applicable): _____ Date: _____/_____/_____