Welcome Dr. Robert Twaddell and his staff at A Healthy Back welcome you and want to provide you with the best possible care. During the course of your treatment, I understand that I will be seen, evaluated and treated by a qualified healthcare professional. We know that filling out these forms can be annoying – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this, we can provide you the best care possible.

Your First Visit

On your first visit, you will consult with the physician about your current symptoms. He will assess your history and condition to determine if you are experiencing any of the common signs of potential spinal "subluxations." These mis-alignments or fixations cause 'jamming' of the vertebrae in the spine that can cause nerve interference.

If this is the case, you will receive a full orthopedic and neurological exam and an x-ray referral will be made, if needed. This allows the doctor to determine your present condition and state of spinal health.

The physician may need some time to assess your exam/x-ray findings, and you will be asked to return for a full report, later that same day, or the following day. Dr. Twaddell will gladly provide you with suggestions to ease any discomfort until the report visit.

Report of Findings

Dr. Robert Twaddell will review your examination / x-ray findings with you, and let you know:

- What is **causing your pain** and/or symptoms?
- If he **can help you**?
- What **plan of treatment** is best for you?
- What plan of treatment is best for your condition?
- **How long it will take** (approx)?
- What is **needed from you** to attain the best results?

Most likely, your condition can be helped with chiropractic care and after your report, you can be ready to begin your treatment.

We will also discuss with you an estimate of your potential care costs, and will gladly discuss your insurance coverage, and all of the options available to you for payment.

$49 Initial Visit Payment

In order to determine if care can be of benefit to you, this office will extend a courtesy of an initial consultation for $20. The most a new patient can expect to pay for a consultation with examination is $49.00. If treatment is provided during the initial visit, it will be discussed prior the given care. This amount is applied to your insurance co-pays until benefits have been qualified. Please be prepared to pay the initial visit charges. **Payment by: [ ] Cash [ ] Check [ ] Visa/ MasterCard/ Debit**

Informed Consent

I authorize the doctor and/or staff to perform the necessary services needed during diagnosis and treatment. I understand that the primary treatment used by doctors of chiropractic is the spinal adjustment. The doctor of chiropractic will use his hands or instrument in such a way as to move my joints. That may cause an audible pop or click much as experienced when one cracks their knuckles. I authorize the doctor of chiropractic to perform spinal adjustments to me. As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, acupuncture, spinal disc decompression, low level laser therapy, range of motion testing, muscle strength testing, radiographic studies, palpation, orthopedic testing, postural analysis, vital signs, basic neurological testing, and electrical stimulation.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns, or stroke (one in 5 million cervical adjustments). Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the doctor.

I authorize the doctor and his staff to release any information deemed appropriate concerning my health care services to my insurance companies, health plan, claims adjuster, case nurse, claims reviewer, health care provider / MD, or attorney in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release them of any consequences thereof.

INFORMATION DISCLOSURE

Protecting the privacy of your personal health information is important to us. Disclosure of 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. This does not apply to the transfer of medical records.

We will periodically forward health care summaries to you in a secure format using Microsoft Health Vault. This service is free to you.

In the future, we may contact you for appointment visits, announcements, and to inform you about the practice and it's staff. Dr. Twaddell is required to abide by this notice. Dr. Twaddell has the right to change this notice in the future. Any revisions will be prominently displayed. You may file a complaint about privacy violations by contacting AHB.

Privacy preferences: Preferred method of phone contact: [ ] Home [ ] Cell [ ] Work

Leaving messages on answering machine (ie. appointments, results): [ ] Request no messages on phone

Family members allowed discussion of care with: [ ] No one [ ] _____

PATIENT INFORMATION

Today's Date: _____ How did you hear about us? [ ] Patient [ ] Doctor [ ] Advertising _____

Name: First, Middle, Last _____

Date of Birth _____ Age: _____ Gender (check one) [ ] Male [ ] Female

Marital Status (check one) [ ] Single [ ] Married [ ] Divorced / Separated [ ] Widowed [ ] Other

Employment Status (check one) [ ] Employed FT/PT [ ] FT Student [ ] PT Student [ ] Other [ ] Retired

SSN _____ Ages of children: _____

Race (check one) [ ] White [ ] Black/African American [ ] Hispanic [ ] Multi-Racial [ ] _____

Contact Info

Address _____

City/State/Zip _____

Phone (H) _____ (C) _____ (W) _____

Email [ ] Home [ ] Work _____

We do not give out your email to anyone. You will receive periodic healthcare updates and specials. You may opt out at any time.

Contact Method [ ] Home Phone [ ] Cell Phone [ ] Cell texts *(appt reminders)* [ ] Work Phone [ ] Email

Employment

Employer / School _____ Occupation _____

Job Description _____

Employment Activities: _____ Physical Stress Level: [ ] Low [ ] Medium [ ] High

Privacy

Verification Question **(choose only one question, then give the answer more than 6 characters to that question)**

[ ] What is the name of your favorite pet? [ ] What city were you born in? [ ] What high school did you attend?
[ ] What is your favorite movie? [ ] What is your mother's maiden name? [ ] What street did you grow up on?

Verification Answer to the Chosen question **(greater than 6 characters)**: _____

Family Information

Spouse or Parent Name: _____ Phone: _____

Insurance [ ] Filing Insurance **Please provide card with paperwork** Insurance Company: _____
CoPay: _____ Is Spouse/Parent Named Insured [ ] Yes Date of Birth: ____/____/_____ [ ] No

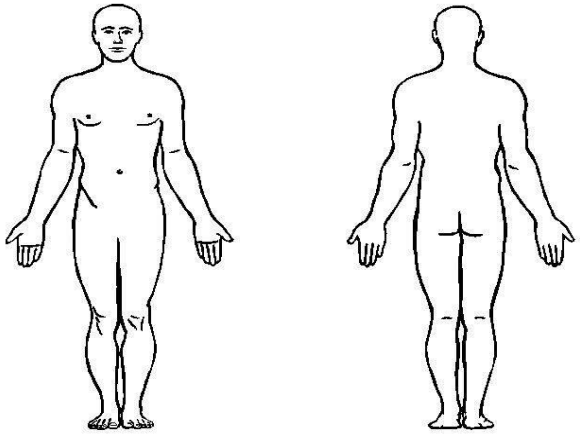
CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with the above stated carrier and assign directly to A Healthy Back all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that there is a $25 missed appointment fee that will be responsible for if not rescheduled with three hours notice. I authorize the use of my signature on all insurance submissions. A Healthy Back may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of patient, parent, guardian, or personal representative Date

Name: _____



What therapies were you inquiring about:

[ ] Unsure
[ ] Chiropractic Manipulation Therapy / Adjustment
[ ] Low Level Laser Therapy [ ] Acupuncture
[ ] Spinal Disc Decompression [ ] Massage Therapy

MARK COMPLAINT AREAS ON PICTURE (TO THE RIGHT)

PLEASE LIST ONLY ONE COMPLAINT AT A TIME.

Complaint #1 (Check only one): _____
[ ] Headache [ ] Neck pain [ ] Neck pain radiating down arm [ ] Shoulder pain [ ] Arm pain
[ ] Upper / Mid back pain [ ] Low back pain [ ] Low back pain radiating down leg [ ] Leg pain
Pain/Intensity: Current _____ / 10 *(0-3 Mild pain 4-7 Moderate pain 8-10 Severe pain)*
Worse (last 7 days) _____ / 10 Least (last 7 days) _____ / 10 Acceptable _____ / 10
Mechanism of injury: [ ] Automobile [ ] Work [ ] Slip / fall [ ] Sports [ ] Lifting [ ] Prolonged driving
[ ] Repetitive motion [ ] Cumulative trauma [ ] Sitting at computer extended time [ ] Cough / sneeze
[ ] Reaching [ ] Lawn work [ ] House chores [ ] _____
Onset: Date _____ [ ] Off and on [ ] More frequent [ ] Gradual insidious [ ] Cumulative [ ] Chronic
Frequency: [ ] Constant (75-100%) [ ] Frequent (50-75%) [ ] Intermittent (25-50%) [ ] Occasional
Timing: Worse [ ] In morning [ ] By midday [ ] At end of day [ ] At night [ ] Throughout day
Radiating to: [ ] Right [ ] Left [ ] Both [ ] Arm to _____ [ ] Leg to _____
Shoulder / Upper Arm / Elbow / Lower Arm / Hand / Buttock / Upper Leg / Lower Leg / Foot
Quality: [ ] Dull [ ] Sharp [ ] Throb [ ] Deep [ ] Ache [ ] Tingle [ ] Stab [ ] Cramp [ ] Numb
Aggravating: [ ] Sitting [ ] Standing [ ] Walking [ ] Bending [ ] Lifting [ ] Sleeping [ ] Sneezing [ ] Coughing
[ ] Straining [ ] Reaching [ ] Twisting [ ] Looking up [ ] Looking down [ ] Movement [ ] Rest [ ] Driving
[ ] Lying on back [ ] Lying on stomach [ ] Typing [ ] House chores [ ] Exercise [ ] Stairs
Relieving: [ ] Sitting [ ] Standing [ ] Lying [ ] Knees bent up [ ] Support [ ] Heat [ ] Ice [ ] Biofreeze
[ ] No movement [ ] Movement [ ] Ibuprofen [ ] Medication [ ] Rest [ ] Stretching [ ] Adjustments
Other treatments: [ ] Medication [ ] Surgery [ ] PT [ ] Injections [ ] Other _____
XRay/ CT/ MRI: _____ Date: _____ Findings: _____
Have you had this injury before? _____ Lost work time? _____
Other notes: _____
_____

Complaint #2: _____
Pain/Intensity: Current _____ / 10 Worse (last 7 days) _____ / 10 Least (last 7 days) _____ / 10 Acceptable _____ / 10
Mechanism of injury: _____
Onset: Date _____ [ ] Off and on [ ] More frequent [ ] Gradual insidious [ ] Cumulative [ ] Chronic
Frequency: [ ] Constant (75-100%) [ ] Frequent (50-75%) [ ] Intermittent (25-50%) [ ] Occasional
Timing: Worse [ ] In morning [ ] By midday [ ] At end of day [ ] At night [ ] Throughout day
Radiating to: [ ] Right [ ] Left [ ] Both [ ] Arm to _____ [ ] Leg to _____
Quality: [ ] Dull [ ] Sharp [ ] Throb [ ] Deep [ ] Ache [ ] Tingle [ ] Stab [ ] Cramp [ ] Numb
Aggravating: _____
Relieving: _____
Other treatments: [ ] Medication [ ] Surgery [ ] PT [ ] Injections [ ] Other _____
XRay/ CT/ MRI: _____ Date: _____ Findings: _____
Have you had this injury before? _____ Lost work time? _____
Other notes: _____
_____

Additional Complaints / Associated or other symptoms: [ ] Headaches [ ] Dizziness / Weakness [ ] Tingling [ ] Anxiety

HEALTH HISTORY

Do you currently smoke tobacco of any kind? [ ] Yes [ ] Never been a smoker [ ] Former, quit _____/_____

If yes, How often do you smoke: ____ Pack / Day [ ] Current Everyday smoker [ ] Current Someday smoker

If yes: What is your level of interest in quitting smoking? _____

List current medications including dosage, if known. If no medications are currently taken then check here:____

1) _____ Dosage _____ Route _____ Freq _____ Quantity _____

2) _____ Dosage _____ Route _____ Freq _____ Quantity _____

3) _____ Dosage _____ Route _____ Freq _____ Quantity _____

Nutritional Supplements:

1) _____ Manufacturer _____ Freq _____ Quantity _____ With water Y/N

2) _____ Manufacturer _____ Freq _____ Quantity _____ With water Y/N

List known allergies. If no allergies are known then check here: _____

1) _____ Medication allergy: Y / N Reaction: _____

2) _____ Medication allergy: Y / N Reaction: _____

What are your health problems / illnesses? Briefly list the name of your problem(s):

[ ] Cancer [ ] Hypertension (401.1) [ ] Diabetes Type I (250.01) / II (250.02) Hemoglobin A1c > 9.0% Y / N

[ ] Heart Disease [ ] Neurological Disorders [ ] Musculo-Skeletal Disorders [ ] Other

Describe _____

_____

Have you had an X-ray or CT scan or MRI of your spine in the past year? [ ] Yes _____ [ ] No

Have you had other diagnostic tests? _____

Family Medical History: Mother: _____ Father: _____

Other: _____

Hospitalizations / Dates: _____

Surgeries / Dates: _____

Primary Care MD: _____ Other MD: _____

Vitals: Height:_____inches (5'0 – 60" 5'6 – 66" 6'0 – 72") Weight: _____ pounds BP: _____/_____

Social: Alcohol _____/wk Coffee _____/wk Soda _____/wk Water _____/wk Sleep _____hrs/day

Pain Reliever _____/wk Healthy Eating (0-10) _____ Exercise Freq _____/wk Type _____

Physical Stress level (0-10) _____ Emotional Stress Level (0-10) _____

Stressors: _____ Things to Improve: _____

Other Health Goals: _____