West Functional Chiropractic
A TOTAL WELLNESS CENTER

# Welcome to West Functional Chiropractic

At West Functional Chiropractic, it is our mission to help you achieve all of your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess this and to understand the root cause of your symptoms, we will be taking you through a series of non-invasive examinations on your initial visit. This will include a full case history, nerve and muscle tests, postural analysis, functional movement assessment, and blood pressure.

On the day of your visit we ask that you wear clothing that you are comfortable moving in for the physical portion of the examination. We will be taking a postural photo of you so please don't wear bulky clothing or multiple layers. Ladies, if you have full tights or pantyhose on, we'll ask that you remove those. In addition to this, if you have any previous X-ray or MRI reports please bring these along on this visit for our records if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take between 45-60 minutes so we ask that you allow sufficient time and if you have any concerns please speak to our reception before your visit if time is a constraint.

**PLEASE NOTE:**
We do enforce a 24 hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late, you do run the risk of our Doctor being unable to see you. If this is the case, please contact our reception staff at 940-668-8755.

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Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Date: _____ Social Security #_____

Name: _____
Last First M.I

Address_____

E-mail (Drs will communicate with you via email) _____

Cell Phone:_____ Home Phone: _____

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School _____

Address:_____

Phone: _____ Occupation:_____

Spouse's Name:_____ SS#_____ - _____ - _____ Phone:_____

Birthdate:_____ Spouse's Employer: _____

Emergency Contact:_____ Relationship:_____ Phone_____

**ACCIDENT INFORMATION**: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

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***INSURANCE INFORMATION:***

*Even if you are here through a non referral source such as a external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.*

Who is responsible for this account? _____ Relationship to patient:_____

Insurance Co:_____ ID#_____

Subscriber Name _____ Birthdate:_____

**ASSIGNMENT AND RELEASE:** I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Jami West, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named 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

_____

Please print name of above signature Relationship to Patient

## ***X-Ray Consent***

I hereby give my consent to West Functional Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____

Patient Signature Date

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## ***Clinical Summary (a required EMR question)***

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

## Financial Responsibility

**Patient Name_____**

Dear Patient,
West Functional Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

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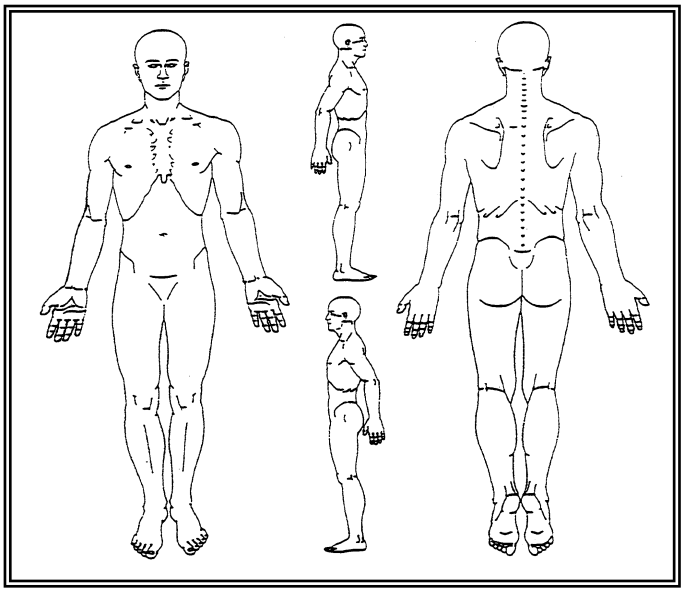
**We appreciate you choosing our office. Is there anyone we can thank for referring you?** _____

**Please indicate the main reason you are seeing us today:** _____

_____

**If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.**

| XXXXXXXXX | / / / / / / / / / / | o o o o o o o o o o | s s s s s | - - - - - - - - |
|---|---|---|---|---|
| **DULL/ACHY** | **SHARP/STABBING** | **NUMBNESS/TINGLING** | **STIFF/TIGHT** | **BURNING** |



**Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:**

**0 = No Pain**. No Discomfort
**1 = Minimal Discomfort**. Minor stiffness or tightness.
**2 = Discomfort**. Stiff, tight, sore. Muscle fatigue.
**3 = Minimal Pain**. More than just sore. Uncomfortable.
**4 = Mild Pain**. Noticeable pain but tolerable.
**5 = Moderate Pain**. Aggravating. Still allows movement.
**6 = Strong Pain**. Quite aggravating. Movement slightly limited.
**7 = Very Strong Pain**. Very aggravating. Movement definitely limited.
**8 = Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
**9 = Severe Pain**. Brings tears. Almost impossible to move.
**10 = Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

**Is there any radiating pain into the arms or legs?** _____ **Is there any numbness or tingling?** _____

**How often do you experience your problem? (Please indicate for each of the body location if applicable)**

Constant (75 – 100% of the time) _____

Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time) _____

Intermittent (0 – 25% of the time) _____

**List any MD's or Chiropractors you've already seen for this problem:** _____
_____

**What tests have you already had for this problem?** □X-rays □MRI □C.T. Scan □Myelogram □EMG/NCV
□None □Other _____

**What makes your problem worse?** □Sitting □Standing □Changing Position □Walking □Bending □Lifting □Twisting
□Reaching □Driving □Sleeping □Sneeze/Cough □Computer Work □Telephone □Going From Sit To Stand
□Other_____

## PAST MEDICAL HISTORY

**Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:** _____

_____

**Please list any surgeries you have had over the course of your life:** _____

_____

## MEDICATIONS & ALLERGIES

**Are you allergic to any medications?** □Yes □No **If yes, please list:** _____

**List any medications, herbs or supplements you are taking and the reason for their use:**

_____

_____

## FAMILY HISTORY

**Mother:** □Living □Deceased List any medical problems: _____

**Father:** □Living □Deceased List any medical problems: _____

**List any problems common in your family:** □Cancer □Diabetes □Heart disease □High blood pressure □Stroke □Arthritis □Scoliosis □Thyroid disease □Osteoporosis _____

## SOCIAL HISTORY

**Marital status:** □Married □Single □Divorced □Common Law □Engaged □Widowed

**Do you have any children?** □Yes □No If yes, how many? _____

**Do you drink alcohol?** □Yes □No If yes, how much & how often? _____

**Do you smoke?** □Yes □No If yes, how much, how often & how long? _____

**Are you currently employed?** □Yes □No If yes, what is your occupation? _____

**Who is your current employer?** _____ **How long have you been at this job?** _____

**What do you do most of the day in your job postures, positions and repetitive movements:** _____-

_____

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**On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:**

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____ = _____

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## REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

| | | |
|---|---|---|
| **Head:**<br>_____ Headaches<br>_____ Faintness<br>_____ Dizziness<br>_____ Insomnia | **Energy/Activity:**<br>_____ Fatigue/Sluggishness<br>_____ Apapthy/Lethargy<br>_____ Hyperactivity<br>_____ Restlessness | **Lungs:**<br>_____ Chest Congestion<br>_____ Asthma, Bronchitis<br>_____ Shortness Of Breath<br>_____ Difficulty Breathing |
| **Eyes:**<br>_____ Watery or Itchy Eyes<br>_____ Swollen, Red or Sticky Eyelids<br>_____ Bags or Dark Circles Under Eyes<br>_____ Blurred or Tunnel Vision (not including near or far sightedness) | **Weight:**<br>_____ Binge Eating/Drinking<br>_____ Craving Certain Foods<br>_____ Excessive Weight<br>_____ Compulsive Eating<br>_____ Water Retention<br>_____ Underweight | **Heart:**<br>_____ Irregular or Skipped Heartbeat<br>_____ Rapid or Pounding Heartbeat<br>_____ Chest Pain |
| **Ears:**<br>_____ Itchy Ears<br>_____ Earaches, Ear Infections<br>_____ Drainage From Ear<br>_____ Ringing In Ears, Hearing Loss | **Emotions:**<br>_____ Mood Swings<br>_____ Anxiety/Fear/Nervousness<br>_____ Anger/Irritability/Aggressiveness<br>_____ Depression | **Digestive Tract:**<br>_____ Nausea, Vomiting<br>_____ Diarrhea<br>_____ Constipation<br>_____ Bloated Feeling<br>_____ Belching, Passing Gas<br>_____ Heartburn<br>_____ Intestinal/Stomach Pain |
| **Nose:**<br>_____ Stuffy Nose<br>_____ Sinus Problems<br>_____ Hay Fever<br>_____ Sneezing Attacks<br>_____ Excessive Mucus Formation | **Mind:**<br>_____ Poor Memory<br>_____ Confusion, Poor Comprehension<br>_____ Poor Concentration<br>_____ Poor Physical Condition<br>_____ Difficulty Making Decisions<br>_____ Stuttering or Stammering<br>_____ Slurred speech | |
| **Mouth & Throat:**<br>_____ Chronic Coughing<br>_____ Frequent Need to Clear Throat<br>_____ Sore Throat, Hoarseness<br>_____ Swollen or Discolored Tongue<br>_____ Canker Sores | | **Other:**<br>_____ Frequent Illness<br>_____ Frequent or Urgent Urination<br>_____ Genital Itch or Discharge |
| **Skin:**<br>_____ Acne<br>_____ Hives, Rashes, Dry Skin<br>_____ Hair Loss<br>_____ Flushing, Hot Flashes<br>_____ Excessive Sweating | **Joints/Muscles:**<br>_____ Pain or Aches in Joints<br>_____ Arthritis<br>_____ Stiffness or Limited Movement<br>_____ Pain or Aches in Muscles<br>_____ Weakness or Fatigued Muscles | **Grand Total:** |