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, heart rate variability 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 _____

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for nay charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

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 Hamilton-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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Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that West Functional Chiropractic is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like West Functional Chiropractic to list as your **Emergency Contact** in the even an emergency situation was to take place at our office.

Contact Name	Relationship to Patient	Contact Phone Number
☐ Billing Account Information	☐ Medical Condition Information	☐ Emergency Contact

Contact Name	Relationship to Patient	Contact Phone Number
☐ Billing Account Information	☐ Medical Condition Information	☐ Emergency Contact

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

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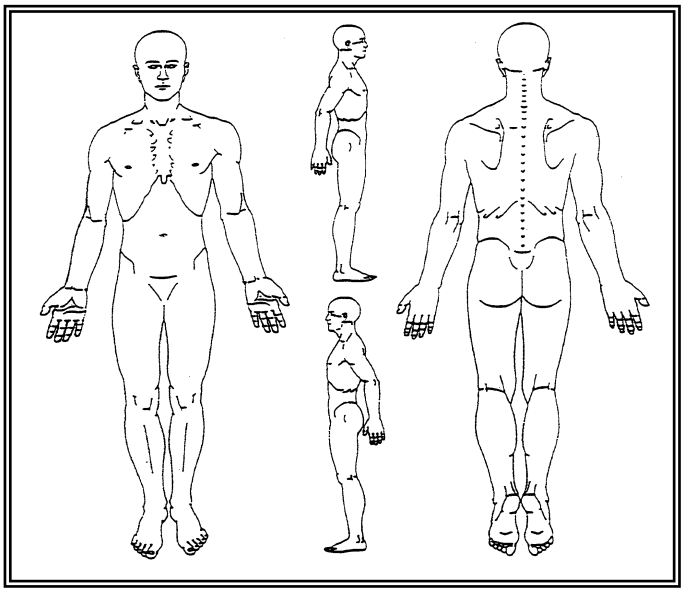
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

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	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: _____-

_____

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

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

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

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **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.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

NOTICE OF APPOINTMENT CANCELLATION/NO-SHOW POLICY

We would like to inform you of a new policy regarding missed appointments and same-day cancellations. Effective November 1, 2015, any patient who misses a scheduled appointment without notifying the office will be subject to a no-show fee.

We now reserve the right to charge you (not your insurance company) for a missed appointment. A $25 fee will be assessed for routine office visits, $30 for missed therapies and trainings, and $35 for missed massage appointments. These fees are subject to change without prior notice.

We ask that you notify our office of any appointment cancellations at least 24 hours in advance. At this time, patients who provide advanced notice for missed appointments will **not** be assessed a fee, but that is subject to change.

We understand extenuating circumstances may prevent you from being present at your appointment, but increasing numbers of missed appointments are negatively impacting our ability to provide excellent care to our patients.

If you have any questions regarding this policy, please do not hesitate to contact our office at 940-668-8755. It is our hope that this policy will reduce wait times and increase efficiency at our office so that we can better serve you with safe, quality healthcare.

Please sign and date below:

_____ _____
Signature Date

_____ _____
Printed Name DOB