# JACKSONVILLE HEALTH AND WELLNESS / CASE HISTORY

## PATIENT INFORMATION

Name_____ Date _____ Sex M F Age _____ Height_____ Weight_____
Birthdate_____ Social Security # _____
[ ] Married [ ] Widowed [ ] Single [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for _____ years
Address_____
City_____ State_____ Zip _____
Occupation:_____ Patient Employer/School:_____

## *SPOUSE/PARTNER*

Name_____ Birthdate_____
Social Security #_____ Employer_____

## *PHONE NUMBERS/CONTACT INFORMATION*

Home Phone (____) _____ Cell Phone (_____) _____
Work Phone (_____) _____
Best time to call and reach you_____ E-Mail address_____
In case of emergency contact:
Name_____Relationship_____ Phone_____

## *PRIMARY MEDICAL DOCTOR*

Doctor Name_____ Practice Name _____
Phone Number_____
Address_____

## *REFFERAL*

How were you referred to our office:_____

## *INSURANCE*

Who is responsible for this account and relationship to patient?_____
Primary Insurance Co. _____Policy #_____ Group #_____
Secondary Insurance Co._____ Policy #_____ Group# _____
Subscriber's Name_____ D.O.B._____ Social Security #_____

## *ACCIDENT INFORMATION*

Is condition due to accident? [ ]Yes [ ]No Date of Accident_____ Type of accident [ ] Auto [ ]Work [ ] Home
Attorney Name (if applicable):_____Have you reported your accident and to whom? _____
Location of Accident_____
Insurance Co. _____ Address_____
Phone #_____ Policy #_____ Claim #_____ Adjuster's Name_____

## *REASON FOR VISIT*

Reason for visit _____
Location/Description of Concern_____
Complaint Began when and how?_____
Please circle quality of complaint/pain: dull ache sharp shooting burning throbbing deep other_____
Does the complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity of today's concern 0 1 2 3 4 5 6 7 8 9 10 (10=worse possible concern/pain)
Is the concern/pain [ ] constant [ ] come and go
How long does it last?_____
Does anything aggravate the concern? _____
Does anything make the concern better? _____

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## *CURRENT/PAST TREATMENTS*

What treatment have you already received for your condition?
[ ] None [ ] Surgery [ ] Medications [ ] Physical Therapy [ ] Massage [] Yoga [] Meditation [] Nutrition Counseling
[ ] Chiropractic (Year)_____ [ ] Other _____

## *PAST/ CURRENT MEDICAL HISTORY*

******IMPORTANT****YOUR CURRENT OR PAST HEALTH, SURGERIES, & MEDICATION WILL EFFECT THE TYPE OF TREATMENT YOU RECEIVE AT OUR OFFICE**

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Work_____MRI_____

Please list **ALL PAST and CURRENT MEDICAL Problems and Conditions**

Please list **ALL surgeries**

Please list ALL **Medications and/or Vitamins and Herbs AND THE REASON FOR TAKING THEM**

Allergies

## *FAMILY HISTORY*

Family Member/Medical Condition: _____
Family Member/Medical Condition:

## REVIEW OF SYSTEMS & DIMENSIONS (Choose all that apply)

**Constitutional** [] unexplained weight loss [] night sweats [] fatigue [] fever [] dizziness
**Metabolic/Hormonal** [] sugar cravings [] weight gain [] irregular/painful cycles [] prostate problems [] loss of libido
**Eyes, Ears, Nose, Throat** [] visual changes [] earache [] increased phlegm production [] sore throat [] ringing in the ears [] enlarged thyroid [] nose bleeds [] pain with swallowing [] bad taste in mouth/bad breath [] allergies
**Cardiovascular** [] chest pains [] exercise intolerance [] poor circulation [] rapid/slow heartbeat [] swelling [] faintness
**Respiratory** [] cough/wheeze [] shortness or difficulty with breathing
**Gastrointestinal** [] abdominal pain [] bloating [] constipation [] diarrhea [] gas [] blood in stool [] acid reflux
**Genitourinary** [] blood in urine [] frequent urination [] kidney infections [] painful urination [] vaginal discharge
**Skin** [] rashes [] itchy skin [] bruise easy [] dry skin [] sensitive skin
**Neurological** [] changes in taste, smell, hearing, or sight [] poor balance [] memory challenges [] concentration problems
**Emotional** [] depression [] anxiety [] racing mind [] sadness [] anger [] frustration [] apathy [] episodes of mania
**Mental** [] lack of self-worth [] body image distortions [] lack of control [] too many demands
**Relational** [] fulfilled [] satisfied [] distraught [] heartbroken (by my close family/friends)
**Spiritual** [] feeling stuck in my current life situation [] fulfilled by my faith, beliefs and spiritual orientation
[] living on purpose [] lack of purpose and unfulfilled

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## *CURRENT LIFESTYLE*

Please describe your current OR past exercise regimen (if applicable) _____

_____

Work Activity: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor [ ] Student
Habits: [ ] Smoking: Packs/Day _____ [ ] Drugs: _____
Sleep Hygiene: [ ] Inability to Fall Asleep [ ] Wake up Often [ ] Other_____
Stress Level: [ ] High [ ] Medium [ ] Low Reason?_____
Fluid Intake (Daily Glasses of): Water___ Carbonated Drinks ___ Dairy ___ Alcohol ___ Coffee ___
Dietary Habits. Please list typical:
Breakfast _____
Lunch _____
Dinner _____
Snacks_____

## WHAT TYPE OF CARE ARE YOU INTERESTED IN?

We offer three types of care at our office. Please let us know what your interest is by checking all that apply?
[] Relief Care: "Please make me feel better. Please concentrate on the SYMPTOMS."
[] Corrective Care: "I would like to concentrate on fixing and finding the root CAUSE"
[] Wellness Care: "I am interested in prevention and furthering myself in the entire health spectrum of mind, body and spirit. I am interested in improving my quality and quantity of life and utilizing holistic solutions for my health-care needs"

## WELLNESS GOALS

Our treatment protocols incorporate a WHOLE BODY approach. We offer a comprehensive array of services for many health-related problems. Therefore, by answering the following questions it will help us to individualize/customize your treatment plan.

| Would you like help with: | NO | YES | Additional Health Goals or Comments |
|---|---|---|---|
| Exercise | [] | [] | _____ |
| Nutrition & Eating Better | [] | [] | _____ |
| Stress Reduction | [] | [] | _____ |
| Weight Loss | [] | [] | _____ |
| Decreased Reliance on Medication | [] | [] | _____ |
| Improving Posture | [] | [] | _____ |
| Flexibility | [] | [] | _____ |
| Learning about wellness | [] | [] | _____ |
| Improving Energy | [] | [] | |

## ACTIVITIES OF DAILY LIVING

Please grade the following activities on how they are impacted by your current health status/condition

| | Unable to perform | | | | | | | | | Able to perform |
|---|---|---|---|---|---|---|---|---|---|---|
| Personal Care | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Lifting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reading & Concentration | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Work | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Driving & Traveling | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sleeping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Recreation | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Hand Coordination | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Walking | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sitting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Standing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Social Life | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Household Duties (laundry, etc.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Exercising | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Patient Signature and Date:**_____

# Jacksonville Health and Wellness Office Policies, Financials & Consent for Treatment

**(Item #1) Consent to Treatment**: I hereby authorize the giving of treatment, performance of diagnostic procedures, examinations and the administration of any other judgment by my physician that may be considered necessary, in good faith, in my best interest, or advisable for my diagnosis or treatment while a patient at Jacksonville Health and Wellness Center. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my physician's recommendations as they may relate to my health that the Physician and this office will not be responsible for any injuries or damages that are the result of my non-compliance. There are inherent risks in any and all treatment delivered by any healthcare provider, ranging from taking a single aspirin to complicated brain surgery. Although we take every precaution, some risks may include, but are not limited to the following:

- Spinal manipulation (Chiropractic): rib fracture, muscle and ligament sprains or strains, injury to intervertebral discs, nerves or spinal cord, and stroke.
- Functional Medicine: allergies or adverse reactions to supplements, dietary changes, or detoxification protocols.
- Massage: soft tissue bruising
- Adjunct therapies (hot packs, electrical muscle stimulation, ultrasound, etc.): burns (i.e. hot packs)

I acknowledge that I have discussed, had the opportunity to discuss, or will discuss (on my consultation) with either the doctor or staff, the risks and benefits of undergoing treatment. Thus, I freely decide to undergo treatment, and hereby give my full consent. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Furthermore, I understand that at any time during course of treatment I can withdraw my consent if done so in a timely manner (i.e. before said treatment).

**(Item #2) Financial Agreement**: I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer.

I also understand that if I terminate my care and treatment, any fees for professional services rendered me at Jacksonville Health and Wellness Center will be immediately due and payable. Lastly, all known and communicated non-covered services (i.e. nutritional supplements) are due immediately upon completion (i.e. end of office visit) unless other arrangements have been made.

*For Medicare Patients Only*:

- Medically necessary Spinal Adjustments are the only covered services permitted by Medicare at our office.
- In order, to establish medical necessity for your adjustment coverage, please note that periodic re-examinations (not covered by Medicare) are required.
- If our office believes your care falls out of Medicare's "medical necessary" treatment guidelines allowed for coverage (i.e. payment for adjustment), we will let you know prior to treatment and provide you with a special Medicare form known as the Advance Beneficiary Notice (ABN) that will explain your options.

**(Item #3) Ackowledgement and Receipt of Privacy Practices:** I Acknowledge that I have received or have been offered a copy of JHWC's Notice of Privacy Practices (available to you at the front desk before signing this consent). This notice provides information on how the office may use or disclose Patient Health Information (PHI) for purposes of treatment, payment, or health care operations. In brief, information revealed during office visits is confidential. Your record and the information contained within it will not be disclosed to others unless you direct us to do so in writing. Exceptions to this confidentiality include disclosure of the intent to harm yourself or others and subpoena from specific government agencies (as outlined in the HIPAA Privacy Rule).

**(Item #4) Authorization, Assignment, and Release (For patients using Insurance):** I hereby assign, direct and authorize my insurance benefits to be paid to *Jacksonville Health and Wellness Center and Dr. Repole* for professional services rendered to me. This is a direct assignment of my rights and benefits under said policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that there is a possibility that I will receive a payment from my insurance company for services rendered from this facility, thus, those payments will be rendered to said facility otherwise I will be billed. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Patient/Policy Holder also authorizes the doctor to complain to the insurance commissioner for any reason. I hereby authorize my insurance carrier to release information regarding my insurance coverage.

**(Item #5) Lab Work and Policies:** All diagnostics (blood, urine, saliva, etc.) ordered will be reviewed with patient on their follow-up appointments. Our office will provide you with time frame for completion (1 week, 2 weeks, etc.) and schedule you accordingly. *It is your sole responsibility to complete requested testing in the time frame allotted and keep your follow-up appointment to review.* Furthermore, inability to obtain required testing in the appropriate time frame is NOT an excuse to cancel an upcoming appointment and avoid our cancellation policy (see below).

**(Item #6) Email & Other Specialty Communications:** Patient understands and acknowledges that communications with JHWC using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, Patient hereby expressly waives JHWC's obligation to guarantee confidentiality with respect to correspondence using such means of communication. Patient understands and acknowledges that all such communications may become a part of his/her medical records. Furthermore, email is never an appropriate vehicle for patient to relay emergency-related concerns.

**(Item #7) Cancellation Policy**: Due to the overwhelming request for consultations, there is a strict 24-hour cancellation policy. Your appointment must be cancelled 24 hours prior to your scheduled consultation, or you will be charged a $50 cancellation fee for all functional medicine appointments and $25 for all other services. You may cancel your appointment by calling the office (note: canceling via email, social media, or text is not acceptable). If calling after hours, please leave a message. As a courtesy, we will call/text to confirm your appointment prior to your scheduled time. Ultimately, it is your responsibility to keep the scheduled appointment or reschedule.

**(Item #8) Emergency:** The Clinic is not a primary or emergency care clinic. You must have a primary care doctor with whom you can consult in the event of an emergency or urgent problem. If you have a serious health problem that requires immediate attention, you should call 911 or have someone take you to the nearest hospital emergency room.

**(Item #9) Late Arrival Appointments:** We are committed to being on time with patients' appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

**(Item #10) Treatment Plan Questions:** We encourage patients to call or e-mail with questions regarding their treatment plan. If there is a need for longer discussion regarding new symptoms or new concerns, then we recommend you schedule an additional follow- up appointment. Questions that require longer than five minute responses fit this scenario. Additionally, if it has been longer than 12 weeks since your last appointment, schedule an appointment rather than email.

Date:

I read, understand, and agree to items 1,2, 3, 4, 5, 6, 7, 8, 9 10 and acknowledge my consent by my signature below. (If there any items that you do not understand or agree to, please list them below)

_____ _____

Patient Name and Signature Witness Name and Signature