ABOVE AND BEYOND HOLISTIC WELLNESS CENTER

HEALING HAPPENS NOW!

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑M ❑F Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

_____

We communicate via text. Please initial _____

HOW CAN WE HELP YOU?

What brings you today? _____

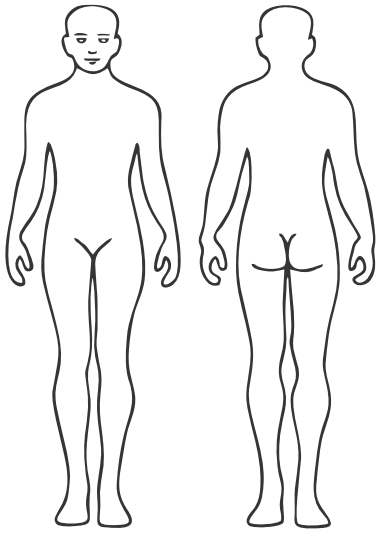
_____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness
❑ Tingling
❑ Stiffness
❑ Dull
❑ Aching
❑ Cramping
❑ Nagging
❑ Sharp
❑ Shooting
❑ Burning
❑ Throbbing
❑ Stabbing
❑ Swelling
❑ Other _____

ABOVE AND BEYOND HOLISTIC WELLNESS CENTER

HEALTH & ILLNESS HISTORY

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues
- ❑ Elbow/Wrist/Hand Issues (R/L)
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues (R/L)
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues (R/L)
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues (R/L)
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

IMPACTING YOUR LIFE

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue? ❶ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NOT COMMITTED — VERY COMMITTED

ABOVE AND BEYOND HOLISTIC WELLNESS CENTER

Rate your concerns on a scale from 1-10 (1 being the least 10 being the most):

Pain management (neck, back, joint)	1	2	3	4	5	6	7	8	9	10
Correcting the cause of any existing ailment	1	2	3	4	5	6	7	8	9	10
Nutrition/herbs to increase overall health	1	2	3	4	5	6	7	8	9	10
Eliminating Negative emotions that may be compromising your health	1	2	3	4	5	6	7	8	9	10
Detoxifying your body of pollutants (Heavy metals, tobacco, blood clot)	1	2	3	4	5	6	7	8	9	10
Allergy/sensitivity elimination	1	2	3	4	5	6	7	8	9	10
Weight loss	1	2	3	4	5	6	7	8	9	10

What 2 aspects of your life are most important to you?

☺ Family ☺ Relationships ☺ Job ☺ Finance ☺ Health ☺ Emotional well-being

☺ Spirituality ☺ Knowledge ☺ Career ☺ Time ☺ Leisure ☺ Communication

What 2 areas would you like to improve?

☺ Family ☺ Relationships ☺ Job ☺ Finance ☺ Health ☺ Emotional well-being

☺ Spirituality ☺ Knowledge ☺ Career ☺ Time ☺ Leisure ☺ Communication

Check all statements that apply to you:

_____ I don't think anything can help me anymore

_____ I'm giving it a try but I doubt it will work

_____ I'm giving it a try and I think it will work

_____ I know I am in the right place

_____ I'm just here to inquire

_____ With the help of God anything is possible

How would you be convinced that something works? (choose only one)

☐ Seeing it ☐ Feeling it ☐ Understanding it ☐ Hearing it ☐ Other:_____

What is important to you when finding a health care provider?

1. That they accept my insurance
2. That they explain things thoroughly
3. That they can help me get to the root cause of my health concerns
4. Other_____

Check any limitations that can interfere with the level of care you receive?

☐ Cost ☐ Time ☐ Commitment ☐ Following through with recommended nutrition

☐ Following through with recommended home care ☐ Fear of not knowing what's going on

ABOVE AND BEYOND HOLISTIC WELLNESS CENTER

Medical History

List all physicians/practitioners you have seen for your **current** condition:

Please list your primary care physician's first/last name, address and phone number:

Have you had any surgeries yes no If yes, when and what?

Do you have any scars yes no If yes, where?

Have you ever been hospitalized? yes no if yes, list reason:

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Have you ever had any of the following diagnostic tests? ☐ X-rays ☐ MRI scans ☐ Bone scan ☐ CT scan

If any selected, list reason: _____

List any previous accidents or injuries: _____

Check all that apply:

- ☐ Smoker
- ☐ Drinks alcohol
- ☐ Takes drugs
- ☐ Non-smoker
- ☐ Does not drink alcohol
- ☐ Does not take drugs

FAMILY HEALTH HISTORY

Condition	Spouse	Children	Father	Mother	Brothers	Sisters
Arm Pain						
Arthritis						
Asthma						
ADD/ADHD						
Allergies						
Back Pain Upper/Lower						
Bed Wetting						
Cancer						
Carpel Tunnel/Wrist						
Constipation						
Depression						
Diabetes						
Digestive Problems						
Disc Problems						
Ear Infections						
Emphysema						
Epilepsy						
Foot/Heel Pain						
Fibromyalgia						
Headaches						
Heart Trouble						
Heartburn/Reflux						
High Cholesterol						
High Blood Pressure						
Hip Pain						
Kidney Trouble						
Leg Pain						
Menstrual Disorder						
Migraines						
Neck Pain						
Nervousness						
Pinched Nerve						
Scoliosis						
Shoulder Pain						
Sinus Trouble						
Smoker						
Sports Activities						
Hypo/Hyper Thyroidism						
TMJ						
Trouble Sleeping						
Other:_____						

Consent to Care

I do hereby authorize the doctors of ABOVE AND BEYOND HOLISTIC WELLNESS CENTER to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure, which is advisable and necessary for my healthcare.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand that any sum of money paid under assignments by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the above agreement.

Signature: _____ Date: _____

Signature of parent or guardian (if patient is a minor): _____

Video Release and Consent:

I, the undersigned irrevocably give Dr. Roger Sahoury, DC, ("Speaker"), its assigns, licensees and representatives, the irrevocable right to use my image, picture, portrait, voice, or photograph in all forms and media and in all manner, for the following purposes: i) Speaker publications, audio/visual presentations and/or Internet pages; and ii) any other media whether electronic or other utilized by Speaker. I understand that Speaker retains the right to use my image, and I waive all rights to ownership, compensation or royalty, if any, which may have resulted from this use. I also waive any rights of privacy in the images and likeness. I hereby waive any right to inspect or approve the finished product, including but not limited to, written copy and/or an image imprint or on a web site, which may be created in connection therewith. I understand that Speaker cannot control the unauthorized use by persons other than Speaker, of my image once such image is published. I agree that any claim I may have concerning unauthorized publication of my image must be pursued by me against the unauthorized user and that I cannot pursue such claim against Speaker. Speaker disclaims any responsibility for such unauthorized use of my published image.

Signature

I have carefully read and understand the provisions contained above, and agree to be bound by them. I voluntarily and irrevocably give my consent and agree to this Release and Waiver. I represent that I am eighteen (18) years of age or older

Signature	Date	Time	Witness

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposerule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care of services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

This patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided herein. The patient may refuse treatment at any time.

Initial _____

Consent to perform and interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third-party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this office. This office reserves the right to charge fair market value for missed appointments or appointments cancelled without advance notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collections of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by the patient to the practice for current and future charges, when incurred.

Initial _____

Print Name:_____

Signature_____ **Date**_____