

# EMPOWER

## HEALTH + PERFORMANCE

### Patient Information

Name: \_\_\_\_\_

Last

First

MI

Mailing Address: \_\_\_\_\_

Address

City

State

Zip Code

Email Address: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Accident Information

Is this visit due to an accident?  Yes  No

If yes, what type?  Auto  Work  Other \_\_\_\_\_ Date of accident: \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

### Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Group Number: \_\_\_\_\_ Secondary Insurance?:  Yes  No

# Patient Health Questionnaire

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Describe your symptoms:** \_\_\_\_\_  
 \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

- Intermittently (0-25% of the day)     Occasionally (26-50% of the day)  
 Frequently (51-75% of the day)     Constantly (76 – 100% of the day)

**Describes the nature of your symptoms:**

- Sharp     Shooting     Dull ache     Burning     Numbness     Tingling     Other: \_\_\_\_\_

**Have your symptoms changed since initial onset?**     Getting Better     Not Changing     Getting Worse

**During the past 4 weeks:** Indicate the average intensity of your symptoms: (circle one)

- 1     2     3     4     5     6     7     8     9     10

| AGGREVATORS:<br>What aggravates your symptoms?   |  | RELIEF:<br>What relieves your symptoms?  |   |
|--|--|--|---|
| <input type="checkbox"/> Bends<br><input type="checkbox"/> Climbs stairs<br><input type="checkbox"/> Coughs<br><input type="checkbox"/> Drives<br><input type="checkbox"/> Goes down stairs<br><input type="checkbox"/> Lying on side<br><input type="checkbox"/> Stands for too long<br><input type="checkbox"/> Is under stress<br><input type="checkbox"/> Certain movements<br><input type="checkbox"/> Is at work | <input type="checkbox"/> Lifts hands over head<br><input type="checkbox"/> Lifts<br><input type="checkbox"/> Picks up child<br><input type="checkbox"/> Working out<br><input type="checkbox"/> Sits<br><input type="checkbox"/> Sleeps<br><input type="checkbox"/> Travels<br><input type="checkbox"/> Turns over in bed<br><input type="checkbox"/> Walks<br><input type="checkbox"/> Working on the computer<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Adjustments<br><input type="checkbox"/> Analgesic cream<br><input type="checkbox"/> Exercising<br><input type="checkbox"/> Heat<br><input type="checkbox"/> Ice<br><input type="checkbox"/> Lying on back w/knees bent<br><input type="checkbox"/> Lying on your side<br><input type="checkbox"/> Massage<br><input type="checkbox"/> Muscle Relaxer<br><input type="checkbox"/> NSAID/ over the counter meds | <input type="checkbox"/> Prescription Meds<br><input type="checkbox"/> Resting<br><input type="checkbox"/> Standing<br><input type="checkbox"/> Stretching<br><input type="checkbox"/> Swimming<br><input type="checkbox"/> TENS Unit<br><input type="checkbox"/> Tylenol<br><input type="checkbox"/> Walking<br><input type="checkbox"/> Yoga<br><input type="checkbox"/> Kinseo-tape<br><input type="checkbox"/> Other: _____ |

**Have you seen any of the following providers for your symptoms?**

- No One   
  Primary Care Physician   
  Orthopedist   
  Physical Therapist  
 Chiropractor   
  Acupuncture   
  Other: \_\_\_\_\_

**What tests have you had for your symptoms & where were they performed?**

- X-rays      Date: \_\_\_\_\_      Where: \_\_\_\_\_  
 MRI          Date: \_\_\_\_\_      Where: \_\_\_\_\_  
 CT Scan      Date: \_\_\_\_\_      Where: \_\_\_\_\_

**Are you currently taking any medication?  Yes  No**

Medications: \_\_\_\_\_

**Have you had any of the following? Please check yes or no:**

|  |   |  |
|--|---|--|
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No         | Previous Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No        | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No       | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       | Night Pain <input type="checkbox"/> Yes <input type="checkbox"/> No     | Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No           | Metal Implants <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No           | Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No      | Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No      |

**Please give a brief explanation and dates for any marked "Yes" above:**

\_\_\_\_\_

**Do you have any medical conditions that are not listed above?  Yes  No**

**If yes, please list:** \_\_\_\_\_

**Indicate if you or any of your immediate family member have/ had any of the following conditions:**

- Arthritis   
  Blood Disorders   
  Heart Problems   
  Diabetes   
  Cancer   
  Epilepsy  
 Other \_\_\_\_\_

## Informed Consent For Chiropractic Treatment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by the doctor or intern affiliated with Empower Health & Performance

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to; fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below, I consent I have read or have had read to me the above consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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Patient or Guardian's Signature

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Date

## Financial Office Policies

1. I understand I am financially responsible for all treatment I receive at Empower Health & Performance. If I have insurance it will be verified promptly and will be reviewed with me. Cash, credit card (Mastercard, Visa, American Express), or checks are acceptable forms of payment for these services.
2. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services at the time of visit
3. The office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered
4. I understand that my insurance may or may not agree to the medical necessity to the treatment received. If they deny any part of a submitted claim I understand and agree to pay the remaining balance on my account after the claim has been processed.
5. I authorize the release of any medical or other records or information necessary to process any claims from this office.
6. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any needs to be taken or is the check on assignment to this office.
7. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
8. I understand there will be a \$25.00 fee for all returned checks.

Thank you for your cooperation in this matter. **I have read and fully understand the financial office policies and agree to abide by these terms.**

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Patient or Guardian's Signature

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Date

## Assignment & Instruction: For Direct Payment to Doctor

I hereby instruct the above name Insurance Company to pay by check made out to and mailed directly to. If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

Schuelke and Wilson Chiropractic Corporation  
DBA Empower Health & Performance  
5836 Corporate Ave Suite 120  
Cypress, CA 90630

This is a direct assignment of my rights and benefits.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

## Cancellation/ No Show Policy

To respect the schedule of the providers, and patients on the waiting list we require a **24 hour** in advance notice for cancellation of appointments. Empower Health and Performance reserves the right to charge a fee of **\$30.00** fee for all appointments that are not canceled 24 hours in advance or for appointments patients do not show up to without advance notice.

"No Show/ Cancellation" fees will be billed to the patient and are not covered by insurance. This fee must be paid prior to your next appointment. Multiple "no shows/cancellations" may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

**By signing below, you acknowledge that you have received this notice and understand this policy.**

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

## Consent for Email / Text Message Reminders

Patients in our practice can be contacted via email and/or text messaging to remind you of an appointment.

I consent to receiving appointment reminders by:  Text message  Email

And/or

I do not consent to receiving appointment reminders via text message or email.

***The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).***

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date