CWCI Crossroads Wellness Center

PERSONAL HISTORY
(Please Print)

Date:_____ Last 4 Digits of Social Security #: _____

Name:_____ Street Address: _____

City: _____ State: _____ Zip:_____E-mail:_____

Contact Phone:_____ Work Phone: _____

Birth Date:_____ Sex: _____ Height: _____Weight: _____

Your Employer: _____ Type of Work: _____

Name & Phone # of Person to Contact in Case of Emergency: _____

Circle If You Are: Married Single Widowed Divorced Separated

Name of Spouse: _____ DOB: _____

Parent/Guardian of Patient (if under age 18)_____

Whom can we thank for referring you?_____

What is your chief complaint? _____

What are some symptoms you are experiencing? _____

FAMILY HEALTH HISTORY

RELATION	NAME	AGE	PRESENT SYMPTOMS	PREVIOUS SERIOUS ILLNESSES
Father				
Mother				
Siblings				
Children				

Patient Account Number:_____

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS – *(indicate date of surgery)*.

OPERATIONS:

Appendectomy _____ Cardiovascular/Heart _____ Female Organs _____

Gall Bladder _____Hernia _____ Rectal _____

Spinal _____ Tonsillectomy _____ Others _____

_____

ACCIDENTS OR FALLS: (Please describe)_____

_____

FRACTURES OR DISLOCATIONS: _____

_____

HABITS: Exercise (what type/how often?) _____Hobbies_____Sleep (hours)_____

Tobacco (How much?) _____ Alcohol_____drinks per ( )day ( )week ( )month

Coffee (avg. # of cups/day) regular_____ decaf._____ Tea (avg. # of cups/day) regular_____ herbal_____

Soft Drinks (avg. # of 12 oz. cans per day) ( )regular_____ ( )diet_____ ( )caf. free_____

Water (8 oz. glasses/day) _____ city_____ well_____ distilled_____ spring_____ filtered_____

List the names and dosages of any drugs you are taking (prescription or non-prescription):

Anti-Inflammatory Medicine _____Laxatives _____

Muscle Relaxers _____Pain Relievers _____
Other _____

Vitamins, minerals, herbs, homeopathic remedies_____

_____

Have you been treated for a mental disorder or nervous breakdown? _____

CIRCLE Any of the Following Diseases You Have Had:

ADD / ADHD Crohn's	Raynaud's Syndrome	Muscular Dystrophy	Cancer
Disease Herpes	Anemia	Tourette's Syndrome	Goiter
Pleurisy	Emphysema	Arthritis	Padgett's
Alcoholism	Infertility	Fibromyalgia	Ulcers
Diabetes	Stroke	Osteoporosis Trigeminal	Candida
Hodgkin's Disease	Anorexia Endometriosis	Neuralgia Bell's Palsy	Heart Disease Parasites
Pneumonia Alzheimer's	Multiple Sclerosis Thyroid	Glaucoma	Venereal Infection
Eczema	Condition Appendicitis	Parkinson's Disease	Chronic Fatigue Hepatitis
Impotency	Epilepsy	Tuberculosis	Phlebitis

Other: _____

Patient Account Number:_____

Underline All of the Symptoms You Have Had Previously
Circle All of the Symptoms You Have Now

GENERAL SYMPTOMS
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Hair Loss
Headache
Hernia
Loss of Sleep
Nervousness
Neuralgia/Nerve Pain
Numbness in arms, hands, or legs
Pain in arms, hands, or legs
Sweats
Tremors
Weak Fingernails
Weight Gain
Weight Loss

E.E.N.T
Allergies
Asthma
Cataracts
Deafness
Dental Decay/Painful Teeth
Ear Discharge
Ear Noises/Ringing
Earache
Enlarged Glands
Enlarged Thyroid
Eye Pain
Failing Vision
Far Sightedness
Frequent Colds
Gum Trouble
Hay Fever
Hoarseness
Macular Degeneration
Nasal Drainage
Nasal Obstruction
Near Sightedness
Nose Bleeds
Sinus Infection
Sore Throat
Tonsillitis

SKIN
Acne
Boils
Bruise Easily
Cysts
Dryness
Hives
Itching
Sensitive Skin
Skin Eruptions
Varicose Veins

RESPIRATORY
Chest Pain
Chronic Cough
Difficult Breathing
Spitting Up Blood
Spitting Up Phlegm
Wheezing

CARDIO-VASCULAR
Cold Hands or Feet
Hardening of Arteries
High Blood Pressure
High Cholesterol
Low Blood Pressure
Pain Over Heart
Paralytic Stroke
Poor Circulation
Rapid Beating Heart
Slow Beating Heart
Swelling of Ankles

MUSCLE & JOINT
Backache
Carpal Tunnel Syndrome
Faulty Posture
Muscle Tightness/Spasm
Pain Between Shoulders
Painful Ankle
Painful Elbow
Painful Foot
Painful Hand
Painful Head
Painful Hip
Painful Knee
Painful Shoulder
Painful Tail Bone
Painful Wrist
Spinal Curvature/Scoliosis
Stiff Neck
Swollen Joints

GASTROINTESTINAL
Belching or Gas
Colitis
Colon Trouble
Constipation
Diarrhea
Difficult Digestion
Distention of Abdomen
Excessive Hunger
Gall Bladder Trouble
Hemorrhoids
Intestinal Worms
Jaundice
Liver Trouble
Nausea
Painful Bowel Movements
Pain Over Stomach
Poor Appetite
Vomiting
Vomiting Blood

GENITOURINARY
Bed Wetting
Frequent Urination
Frequent Kidney or Bladder Infections
Inability to Control Urine
Kidney Stones
Painful Urination
Prostate Trouble
Pus/Blood in Urine

FOR WOMEN ONLY
Cramps
Excessive Flow
Irregular Cycle
Lumps in Breasts
Menopausal Symptoms
Painful Menstrual Periods
Previous Miscarriage
Vaginal Discharge

Are you Pregnant? ( ) Yes ( ) No

Do you think you might be Pregnant?
( ) Yes ( ) No

Patient's Signature: _____ Date: _____

Patient Account Number:_____

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HIPAA Privacy Notice

Crossroads Wellness Center strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time you may request to view or receive a copy of our HIPAA policy.

To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA policy has been made available to you upon request.

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are due at the time of service, unless prior arrangements have been made. Our office accepts assignment with most insurance companies, however **INSURANCE IS NOT A GUARANTEE OF PAYMENT**. Your insurance is an agreement between you and your insurance company. All insurance assignment patients must pay their deductibles in full and copayment/coinsurance at time of service. Please be advised that we will not write-off any massage service for any reason by any insurance company, even if we are contracted with your insurance company. If our office has not received payment by your insurance company within forty-five (45) days of our office filing the claim, you will become responsible for payment in full.

I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to, the examination, consultation, and/or treatment. I also agree to pay a service charge of $35.00 if my check is returned for insufficient funds. I understand that this service charge may be in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month may be assessed on delinquent balances. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my account.

INFORMED CONSENT FOR CHIROPRACTIC/NATUROPATHIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: Naturopathic medicine, physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic at Crossroads Wellness Center and/or the doctor of Naturopath and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN AFTER YOU AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ Date _____
Signature of Patient

X_____ Date _____
Signature of Representative (if patient is a minor or POA)

Patient Account Number:_____

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MASSAGE THERAPIST/PATIENT CONTRACT

The relationship between the massage therapist and the patient is one built on trust and mutual respect. In order to preserve this relationship, the patient should be mindful of our policies before the first session begins.

WHAT PATIENTS CAN EXPECT FROM US:

1. Patients are treated with respect and dignity.
2. Privacy and confidentiality are maintained at all times.
3. Patients are provided with a competent, professional massage.
4. All patients are draped with a sheet and only the part of the body being worked on is exposed at any time.
5. Our office retains accurate records and review them before each session.
6. All massage therapy is under the direction and supervision of Dr. Caleb Suciu.
7. Our office maintains all massage therapy equipment and supplies to be safe and clean.
8. Our office performs services within the scope of our practice.
9. Our office charges per unit (15 minutes) for massage therapy performed under the direction of the doctor.
10. Our office will bill your insurance with the appropriate service code and diagnosis. If your insurance company allows the billed code it will be applied to your deductible and/or copay. **PLEASE NOTE: INSURANCE IS NOT A GUARANTEE OF PAYMENT. Please be advised that we will not write-off any massage service for any reason by any insurance company, even if we are contracted with your insurance company.**

OUR REQUIREMENTS OF PATIENTS:

1. Massage sessions begin and end at scheduled times. Massages that begin late due to the patient arriving late, end at the appointed time and are charged for the full session.
2. Payment is due at time of service, unless prior arrangements have been made with the front office.
3. If cancellation is necessary, please provide our office with at least a 12-hour notice. Otherwise, you will be charged for the appointment unless it can be filled.
4. Patients must provide our office with updated information as necessary on medical history, address, phone number, and insurance.
5. Parents or guardians must be present for massages of minors.
6. Our office will call your insurance company to receive your massage benefits. Customer service may state that these services are covered under your plan. ***However, please be advised that your insurance company also informs us that insurance is not a guarantee of payment***. Therefore, you are ultimately responsible for all services provided by our office.
7. Sexual harassment is not tolerated. If the massage therapist feels their safety is compromised, the session stops immediately, and you will be dismissed as a patient.
8. Please be aware that the use of essential oils may be used during your massage. Please let your therapist know if you object to the use of essential oils.

I have read and agree to the above terms and consent to massage as explained to me.

_____
Printed name of Patient

x_____ Date _____
Signature of Patient

X_____ Date _____
Signature of Representative (if patient is a minor or POA)

Patient Account Number:_____