



Chiropractic Wellness
By Dr. George Tomes, LLC
George Tomes, D.C.

PATIENT GENERAL INFORMATION QUESTIONNAIRE

****Please Print Clearly. Please complete ALL information on this form (7 pages).****

Today's date: _____/_____/_____

Please help us to spell your name correctly by block printing it!

PERSONAL INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell / Mobile Phone _____ Best number to call for appointment reminders _____

E-mail _____

Birth date _____ Age _____ Sex: Male Female Height _____ Weight _____

Occupation _____ Employer _____

If patient is a minor, parent / guardian name(s): _____

Emergency Contact Name _____ Phone _____

Referred by (how did you hear about us?): _____

FINANCIAL INFORMATION

Person responsible for payment Self Auto Insurance (coverage must be verified)

Method of payment Cash Check Credit Card

I (we) agree to pay for services rendered to the abovementioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payments of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Name: _____ Date: _____

CHIEF COMPLAINT/REASON FOR VISIT

Are you currently involved in a lawsuit or pending litigation over an injury? Yes No Date _____

Please check all conditions that in your past medical history involving injuries, surgeries, or medical treatment.

| Condition | | Have you had any auto or other accidents? Yes <input type="checkbox"/> No <input type="checkbox"/> Describe below. |
|-----------------|--------------------------|---|
| Ankle pain | <input type="checkbox"/> | |
| Arm pain | <input type="checkbox"/> | |
| Back pain | <input type="checkbox"/> | |
| Foot pain | <input type="checkbox"/> | |
| Hand pain | <input type="checkbox"/> | |
| Hip pain | <input type="checkbox"/> | |
| Joint stiffness | <input type="checkbox"/> | |
| Leg pain | <input type="checkbox"/> | |
| Elbow pain | <input type="checkbox"/> | |

Please check all conditions that apply to you or your family's past medical history.

| Condition | You | Family | Condition | You | Family |
|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Broken bones | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Eye/vision problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Genetic spinal condition | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing problems | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological problems | <input type="checkbox"/> | <input type="checkbox"/> | Pace maker | <input type="checkbox"/> | <input type="checkbox"/> |
| Parkinsons | <input type="checkbox"/> | <input type="checkbox"/> | Polio | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate | <input type="checkbox"/> | <input type="checkbox"/> | Significant weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke/heart attack | <input type="checkbox"/> | <input type="checkbox"/> | | | |

DRUGS, MEDICATIONS, SUPPLEMENTS

Current medications/drugs being taken, including "over the counter" medications: (use a separate sheet if needed:)

| DRUG NAME | Taken for what symptom or condition | Taken how often? | Approx. starte date (or years ago) | Are you experiencing any side effects? |
|-----------|-------------------------------------|------------------|------------------------------------|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Name: _____ Date: _____

Please list any dietary supplements that you take regularly:

List any allergies or foods/substances you are sensitive to:

| Allergy | | Allergy | |
|--------------------|--------------------------|------------|--------------------------|
| Animals | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> |
| Bees | <input type="checkbox"/> | Dairy | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | Dust | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> | Foods | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> | Molds | <input type="checkbox"/> |
| Rag weed/pollen | <input type="checkbox"/> | Rubber | <input type="checkbox"/> |
| Seasonal allergies | <input type="checkbox"/> | Shell fish | <input type="checkbox"/> |
| Soaps | <input type="checkbox"/> | X-ray dye | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | | |

Name, address and phone number of medical doctor:

Date of last visit and why? _____

DIET AND LIFESTYLE:

- Coffee _____ cups/day
- Tea _____ glasses/day
- Alcohol: What kinds and how often: _____

Have you consumed large amounts of alcohol, or had frequent drinks over a period of a year or more (currently or in the past)? _____

- Chocolate or candy _____ Times per day
- Diet soda _____ Times per day
- Regular soda _____ Times per day
- Artificial sweeteners _____ Times per day
- Sugar _____ Times per day
- Laxatives _____ Times per day
- Fast food _____ Times per day
- Milk/cream _____ Times per day
- Cigarettes/tobacco use: _____ Times per day How long? _____
- Recreational drugs: What drugs and how often? _____
- Past recreational drugs: If any heavy use of drugs in past, what drugs and how long ago? _____

SOCIAL HISTORY:

Are you Married Widowed Single Divorced Domestic Partner

Number of Children: _____ Number of Children Living in Household: _____

Please check your educational level:

- High school/GED Some college College graduate
- Trade school Graduate degree

Name: _____ Date: _____

THIS NOTICE IS PRESENTED IN COMPLIANCE WITH FEDERAL HIPAA REQUIREMENTS FOR HEALTH CARE PROVIDERS & DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

We Will Keep Your Medical Information Confidential. We will act to keep your health related information private except that you allow us to release pertinent information to:

1. Your insurance company or other 3rd party payer, so they can pay your bill.
2. Your other doctors, for information you want them to have from us.
3. Your attorney, or anyone else you request and authorize us to release it to.
4. Our business partners. Examples: Outside billing companies, outside marketing companies that might produce and mail our newsletters, etc. If we use any such company, they too will maintain the same level of privacy we maintain.
5. Your legal representative(s), should you for any reason become unable to speak and or act for yourself in making health care related decisions.
6. Your providers of emergency treatment as consistent with our awareness of your needs and the doctors best judgment. Example: You are in the emergency room and they need medical information about you from us.
7. Your family, friends or others that may answer your phone, read your mail, or otherwise communicate with us as part of our exchanging information with one another that is necessary to your care and relationship with this office. Examples: We can call your home and leave a message for you on your answering machine or with any person that answers. We can send you a fax or e-mail that might be read by any other person with access to your fax or e-mail. We can leave a message for you at work on any recording device or with any person limited to our name, phone number, and the level of necessity / urgency that you contact us.

APPOINTMENT REMINDER, BIRTHDAY CARDS & NEWSLETTERS The Practice may contact you to provide appointment reminders, information on treatment alternatives or other health related information, offers, benefits and services that may be of interest to you. The following communications are used by the practice:

1. Postcards mailed to you at the address provided by you.
2. Telephoning your home and leaving a message on your answering machine or with the individual answering the phone.
3. We will remember you on your birthday with a customary card.
4. Newsletters, with health information we believe to be valuable to you, will be sent periodically.
5. Ordinary practice related information may be communicated to you by any physical or electronic method that may be available and deemed reasonable and appropriate by the compliance officer.

PRIVACY OFFICER – GEORGE TOMES, DC

Dr. Tomes is responsible for all privacy issues and can be contacted by phone or mail at our office. Dr. Tomes will maintain HIPAA privacy compliance and may change the terms of this privacy policy without notice to best preserve the privacy of your information. You are entitled to a copy of this policy and any future changes that may affect your information.

AGREEMENT AND SIGNATURE AS OF ____/____/____ By signing below I acknowledge that I understand and agree to the above and have indicated any restrictions I wish to apply to my records on the reverse side of this page.

Patients Name: _____

Signature of Patient: _____

Parent or Guardians Name: _____

Signature of Parent or Guardian: _____

Name: _____ Date: _____

INFORMED CONSENT FOR NUTRITIONAL CONSULTING

This is not medical treatment. This is only nutritional support.

DO NOT STOP TAKING ANY MEDICATIONS WITHOUT SEEKING THE ADVICE OF A MEDICAL DOCTOR.

Discontinuing medical treatment without the advice of a medical doctor could seriously damage your health or cause death.

Signature _____ Date _____