STANLICK
chiropractic

241 W. Northfield Blvd
Murfreesboro, TN 37129
615-907-7400

Date______________________

PATIENT INFORMATION

Patient Name_______________________________________
__________________SS#_____________________
Address _____________________________ Apt ________
City ____________________ State ______Zip__________
Home Ph ________________ Cell Ph__________________
Email _______________________________________
Sex ☐ M ☐ F Age _____ Birthday______________

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer_______________________________________
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?

____

HOW CAN WE HELP YOU?

Describe your current problems and how it began ____
☐ Work related. ☐ Auto related ☐ Other (explain) ______________________________________
Approximate date problem began ________________________ How problem began___________________________

How bad is it? How intense are your symptoms? (circle) 0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

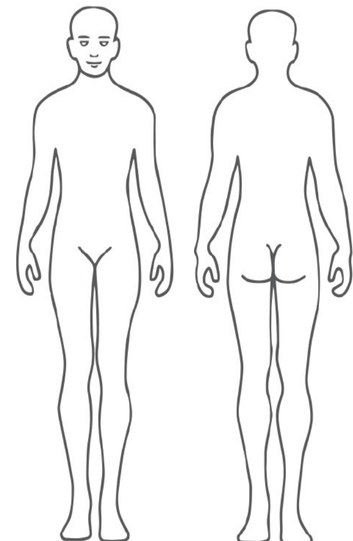
How often are the symptoms present?________________________________

In the past week, how much as your problem interfered with your daily activities (eg. Work, social activities or household chores)?
Circle below

0 (NO INTERFERENCE) 1 2 3 4 5 6 7 8 9 10 (UNABLE TO CARRY ON ANY ACTVIITIES)

Have you had spinal x-rays, MRI, CT scan for your area(s) of complaint? ☐ No ☐ Yes Date taken ________________
What areas ______________________

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



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing
☐ Cramping ☐ Swelling
☐ Nagging ☐ Other __________________

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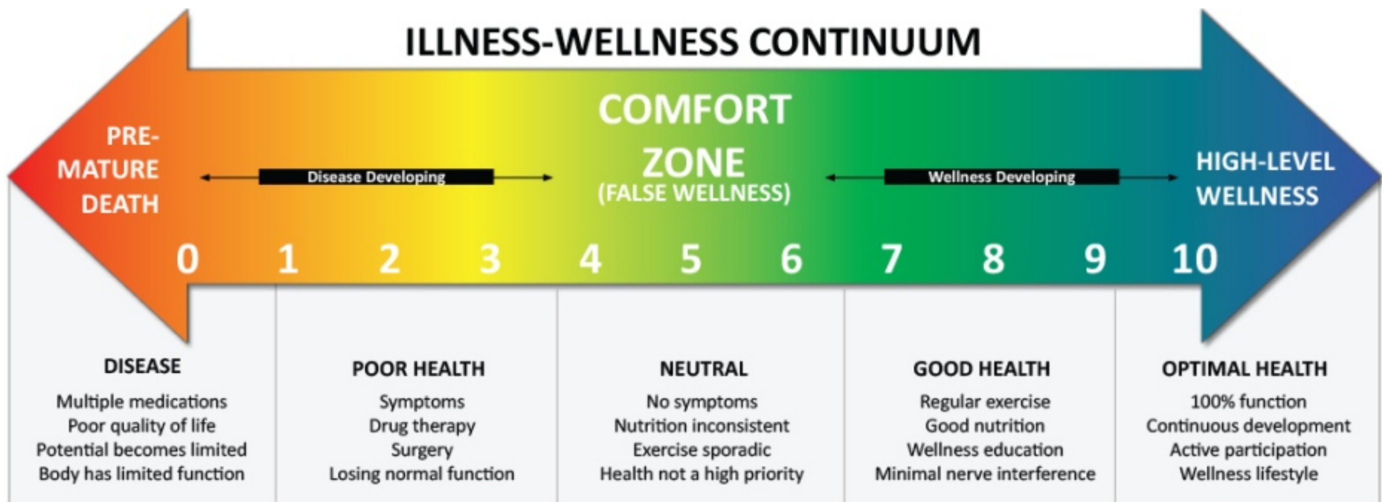
IMPACT OF YOUR SYMPTOMS

	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?

1 NOT COMMITTED 2 3 4 5 6 7 8 9 10 VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



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

____

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CHILDREN & PREGNANCY

How many children do you have? ____________

Children's ages? ____________________________

Children's health concerns?

____

Are you currently pregnant? No. ☐ Yes, I am due __________ ☐

Number of past pregnancies? ______________________________

Health concerns regarding this pregnancy?

____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (List)	MEDICATIONS (List)	SUPPLEMENTS (List)

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Have you experienced chiropractic care before?	Yes / No	If yes, was it a positive / negative or neutral experience?
What percent of your diet consists of fruits and vegetables?	%	
How many ounces of water do you consume on average, daily?	ounces	
How much alcohol do you consume?		None / Once in a while / Weekly / Daily / Multiple times per day
Do you smoke?		None / Once in a while / Weekly / Daily / Multiple times per day
Do you exercise?		None / Once in a while / Weekly / Daily / Multiple times per day
Are you healthier now than you were 5 years ago?		
List any surgeries:		
Any family history of?	Diabetes / Heart Disease / Cancer / Rheumatoid Arthritis / High Blood Pressure	
When do you generally feel your worst?	A.M / Noon / P.M.	
How committed to your health are you?	Not 1 2 3 4 5 6 7 8 9 10 Extremely	

ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT

I hereby consent to a chiropractic evaluation and examination, x-ray(s), chiropractic treatment(s), decompression, k-laser, supplements, healthy lifestyle information (books, CD's, DVD's, etc.), or activities of daily living information rendered to the client which our doctors may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Stanlick Chiropractic. I hereby authorize the above named doctor(s) to release information requested on this form, and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I know I am responsible for payment of my account, and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductible, coinsurances and co-pays are my responsibility to pay.

TERMS

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1.5% per month (annual percentage rate 18%) of unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

NOTICE OF PRIVACY PRACTICES

The federal government has passed the Health Insurance Portability and Accountability Act ("HIPAA") to protect your Personal Health Information ("PHI"). HIPAA took effect on April 14, 2003. Implementation of ,and compliance with, HIPAA is not an option for Stanlick Chiropractic.

Sign below indicating that you have had the opportunity to receive a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will need an Acknowledgment Form signed by you on behalf of the patient.

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of: Stanlick Chiropractic and all my questions have been answered to my satisfaction in language that I can understand.

Signature________________________________ Date____________________

Relationship______________________________ DOB____________________

Witness__________________________________

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CONSENT FOR CHIROPRACTIC CARE

I here by request that Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Buzz Hull D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C. provide chiropractic services for me (or my minor child, whose name appears below). I understand that the care is to be provided by Mitch Stanlick,D.C., Jeremy Bills,D.C., Cash McMeans,D.C., Buzz Hull D.C., Garrett Webb, D.C., Jonathan Sheridan,D.C. and/or designated assistant. Mitch Stanlick,D.C., Jeremy Bills,D.C., Cash McMeans,D.C., Buzz Hull D.C., Garrett Webb,D.C., and/or Jonathan Sheridan,D.C. has discussed my care with me, and I understand that:

1. The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.
2. Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis of medical conditions is not a primary goal. However, I will be informed of abnormal findings.
3. Chiropractors do not give medical advice, nor do they discourage me from receiving medical advice. If deemed advisable, Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Buzz Hull, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C. will refer me for medical services with all possible diligence.
4. Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Buzz Hull, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C. uses only chiropractic methods that are taught in accredited colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.
5. Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.
6. Although the risks are very minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.
7. Because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.
8. I am an active participant in my chiropractic care, and I am therefore invited to ask any questions or express any concerns that I may have.
9. I am free to withdraw my consent and discontinue care at any time.

☐ Signing below on behalf of self
☐ Signing below on behalf of minor
☐

Signature ______________________________ Date ____________

Witness ______________________________ Date ____________

Witness (printed) ______________________________

CONSENT TO EVALUATE AND TREAT A MINOR
ONLY pertains if filled out on behalf of minor -****Skip to signature if signing on behalf of self***

By signing below, I, ____________________________________ being the parent/legal guardian of _________________________do hereby grant permission to the treating staff doctor to perform chiropractic services to the minor listed above.
I have read the above statements and understand Stanlick Chiropractic's objectives pertaining to my care in this office.