

PATIENT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (CELL) _____

DATE OF BIRTH _____ AGE _____ SEX M F

MARITAL STATUS: SINGLE, MARRIED, LEGAL PARTNER, DIVORCED, WIDOWED

OCCUPATION: _____ EMPLOYER _____

EMAIL: _____

EMERGENCY CONTACT NAME _____ PHONE _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

FINANCIAL POLICY

Our practice is a fee for serviced practice. Full payment is required at time of service. You will receive a detailed receipt that can be submitted to your insurance company. We are non-participating Medicare providers so payment is due at time of service. Approved BWC claims will be submitted for the injured worker and payment will be accepted from BWC. No third party auto insurance claims will be accepted.

FEES

New patient exam including one treatment \$165 Re-exam \$55

Acupuncture \$80 Chiropractic \$60 PT modalities only \$60 Class IV Laser \$60

We accept cash, check, CC, HSA/FSA Returned check fee is \$45

No show fee without 24 hr notice will be \$60.

I acknowledge that I am fully responsible for all charges incurred at Polaris Wellness.

Signature _____

ACKNOWLEDGEMENT OF PRIVACY NOTICE/HIPAA CONSENT

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices and I consent to this information of my protected health information for use by Polaris Wellness/Dr. Hindman.

Signature _____

SYMPTOMS Reason for visit: _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? Yes No Same Better

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking
 Bending Lying down Other _____

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain):
1 2 3 4 5 6 7 8 9 10

How frequent is the condition? Constant Daily Intermittent Night Only

Is there anything you can do to relieve the problem? Yes No If yes, describe, _____

Have you ever had the same or a similar condition? Yes No If yes, when, _____

List any major accidents you have had? _____

What treatment have you already received for your condition?
 Medication Surgery Physical Therapy Other _____

Name and address/phone numbers of other doctor(s) who have treated you for your condition: _____

HEALTH HISTORY

Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson=s Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | |

Name of Family Physician: _____ May we contact: Yes No

Physician Phone Number & Address: _____

Date of last exams: _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

DAILY HABITS

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? Yes No How much per day? _____

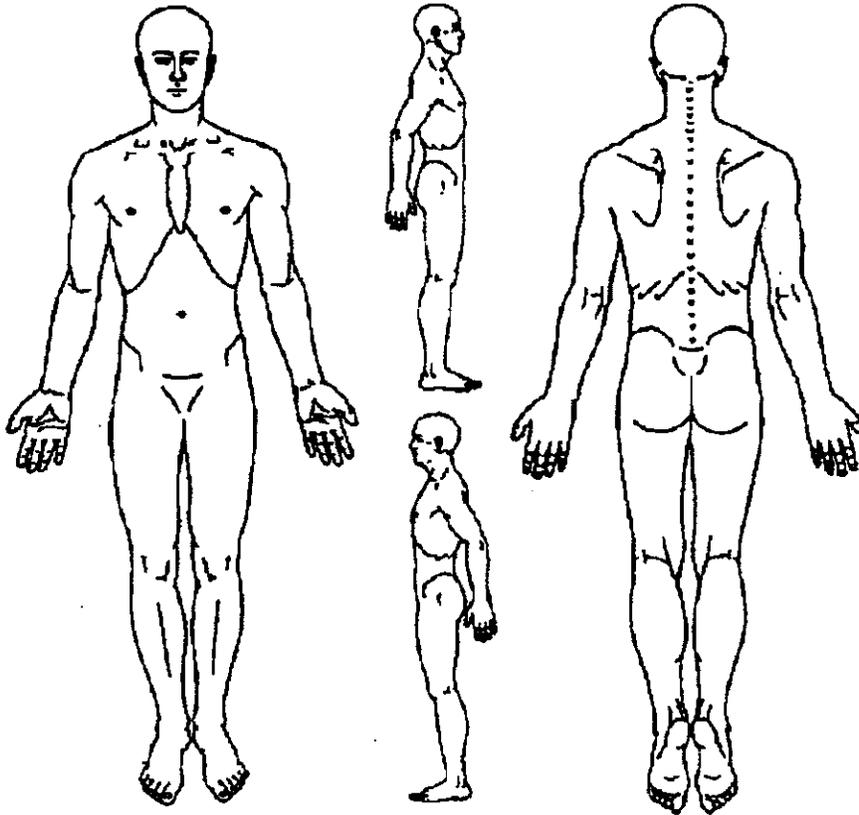
How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____

DATE _____

No Pain | _____ | Worst Possible Pain

Please make a slash through this line as to the level of your pain.

Patient Signature

Polaris Acupuncture & Chiropractic Center LLC
Dr. Shauna Hindman D.C., Dipl.Ac
110 County Line Road West, Suite B
Westerville, OH 43082

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic, acupuncture and/or related procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Shauna Hindman, D.C., Dipl.Ac. and /or other health professionals who are serving as back-up for Dr. Hindman.

I understand that methods or treatment may include, but are not limited to, chiropractic, acupuncture, electric stimulation, ultrasound, massage, hot or cold packs, traction, supplements/herbal medicine, and nutritional/lifestyle counseling. I have the opportunity to discuss with Dr. Hindman the nature and purpose of chiropractic or acupuncture treatment and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been rare instances reported in the literature of fainting, infections, scarring, spontaneous abortions, and pneumothorax. Dr. Hindman uses pre-sterilized, disposable needles exclusively in her practice. If I become pregnant, I will inform Dr. Hindman.

If I experience any gastro-intestinal upset or allergic reactions to the herbs/nutritional supplements I will inform Dr. Hindman.

Chiropractic care involves certain complications that include but are not limited to fracture, stroke, disc injury, dislocations, strains, stiffness, and soreness. These complications are rare and Dr. Hindman will make every reasonable effort during the exam to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. You may have other treatment options for your condition. These may include self-administered over the counter medicine and rest, medical care with prescriptions, hospitalization, or surgery.

I do not expect Dr. Hindman to be able to anticipate and explain all possible risks and complications. I wish to rely on her to exercise good judgment and to provide treatment regarding my best interests. I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my prior written consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo treatment recommended by Dr. Hindman. 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. I certify I understand what I have read and am of sound mind.

Signed _____ Date _____

Patient's Name _____ (please print)

Signature of Parent or Legal Guardian _____

Relationship to patient _____