

TO THE NEW PATIENT

Please complete all sides of this form as accurately and completely as possible. Some information may not appear to be related to your problem, however, experience has proven that providing comprehensive information is essential to getting you better as quickly as possible. Whatever additional information you provide will be helpful in evaluating your condition.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient or Guardian's signature _____

PERSONAL HISTORY

Please print carefully. We want all the facts about your health before we accept your case.
Your report is confidential and treated as such by our staff.

Today's Date _____

Name _____ Address _____

City _____ State _____ Zip _____ Birth date _____

Home Phone _____ Fax # _____ Age _____ Sex M F

SS # _____ Spouse's SS # _____ No. of children & ages _____

Employer _____ Type of Work _____ Work phone _____

Cell phone _____ Referred to this office by _____

Marital Status (check one) Married Single Widowed Divorced Separated

Who is responsible for your bill? You and Spouse Worker's Comp Auto Ins. Medicare Major Medical

Insurance company _____ ID # _____

What is your usual sleeping position? back side stomach E-mail _____

What is the purpose of this appointment?

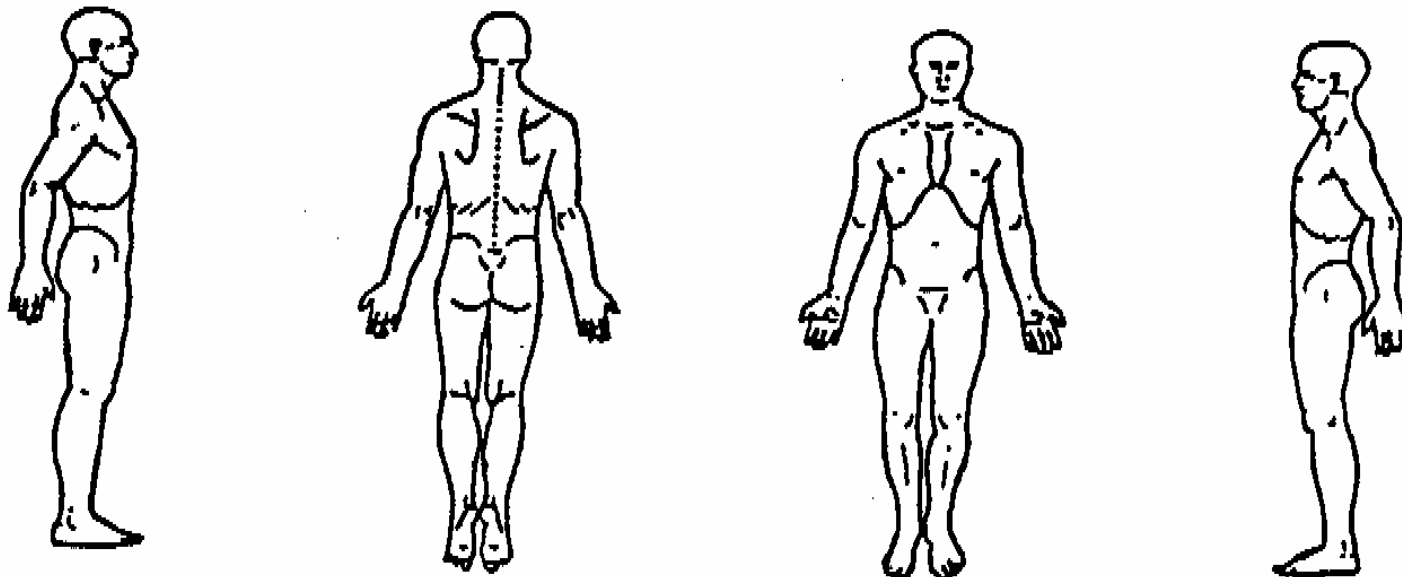
Do you suffer from any other medical condition? If Yes, please describe:

CURRENT HEALTH CONDITIONS

When did your symptoms start? _____ Is this condition: Job Related Auto Accident Other:

Describe your symptoms and how they began: _____

Please indicate the areas of problem(s) on the appropriate figures below:



Please put a mark on the scale to show how bad your usual discomfort has been recently.

No discomfort

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Worst possible discomfort

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

- Sharp Shooting
- Dull Ache Burning
- Numbness Electrical
- Tingling

Since your problems began are your symptoms changing? Getting better Not changing Getting worse

List other doctors have you seen for this condition: chiropractor medical doctor physical therapist other

What tests have you had for your symptoms? X-rays CT scan MRI Blood tests _____

Have you had the same or similar symptoms in the past? Yes No

As a result of your symptoms are you restricted in your ability to perform work and/ or daily activities Yes No

If Yes, Describe your restrictions: _____

What type of exercise do you perform? None Light Moderate Strenuous Aerobic Weight training Stretching

PAST HISTORY

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE EVER HAD:

- | | | | | |
|--|--|---|--------------------|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | DO YOU USE: | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Small pox | <input type="checkbox"/> Pleurisy | | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental disorders | | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lumbago | | <input type="checkbox"/> White sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | | <input type="checkbox"/> Pot |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Allergies | <input type="checkbox"/> Psoriasis | | <input type="checkbox"/> Other drugs |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain Stiffness
- Walking problems
- Difficulty chewing or Clicking jaw
- General stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion or Depression
- Fainting
- Convulsions
- Tingling or Cold extremities
- Stress

GASTROINTESTINAL

- Poor or Excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight trouble
- Abdominal cramps (not menstrual)
- Gas or Bloating after meals
- Heartburn
- Black or Bloody stools
- Colitis

GENERAL

- Fatigue
- Allergies
- Loss of sleep
- Fever
- Headache Migraines

GENITO-URINARY

- Bladder trouble
- Painful or Excessive urination
- Discolored urine
- Prostate or Sexual dysfunction

CARDIO-VASCULAR

- Chest pain
- Shortness of breath
- High blood pressure
- Irregular heartbeat
- Heart problems
- Lung problems or Congestion
- Varicose veins
- Ankle swelling
- Stroke

EYES EARS NOSE THROAT

- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Hearing difficulty
- Stuffed nose

FEMALE ONLY

- Menstrual irregularity
- Menstrual cramps
- Vaginal pain or Infection
- Breast pain or lumps
- Are you pregnant? Yes No
- Date of last period: _____

MEDICATION or VITAMINS YOU TAKE?

- Birth control pills _____
- Aspirin/Tylenol _____
- Ibuprofen _____
- Pain killers _____
- Muscle relaxant _____
- Blood pressure _____
- Diabetic _____
- Thyroid _____
- Heart _____
- Hormones _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

MAJOR SURGERY OR OPERATIONS:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Back |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Other _____ | |

FAMILY HISTORY

The following members have a same or Similar problems as I do:

- Mother
- Father
- Brother
- Sister
- Child

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of natural, non-invasive methods such as spinal adjustments, massage, nutrition or acupuncture.

Patient's signature **X** _____ Date _____

Guardian's signature (if patient is a minor) _____

COMPLETE THIS SECTION *ONLY* IF YOUR CONDITION IS DUE TO AN ACCIDENT.

FOR AUTO ACCIDENT or NON-WORK RELATED ACCIDENTS:

Are you presently disabled as a result of the accident? YES NO

Date _____ Time _____ Police report? YES NO

Were you the DRIVER or PASSENGER ? (Check one) Seat belt on? YES NO

Were you taken to the hospital? YES NO By ambulance? YES NO

Owner of vehicle: SELF OTHER WHO? _____

Location of accident _____

Description of accident _____

Have you notified the insurance company? YES NO

Name & address of insurance company _____

Do you have an attorney for this case? YES NO If YES, name and address: _____

FOR WORK-RELATED ACCIDENTS:

Have you notified your employer? YES NO Name of supervisor _____

Employer's address _____ Employer's phone _____

Was an accident report completed? YES NO When? _____

Date injured _____ Time _____ Date last worked _____

Location & description of injury _____

Name & address of insurance company _____

I authorize payment of medical benefits to the undersigned practitioner.

Signature of insured or authorized person: **X**

CONTEXT OF CARE OVERVIEW

1. What expectations do you have around your care with us?

2. Can you envision yourself being healthy, happy and free from your present health challenges at some point in the future? YES NO

If yes, how long do you see or feel this process taking? _____

3. Do you believe there is any purpose to your present signs and symptoms? i.e.: Is there a possible message or positive intent associated with them? Could your body's inherent wisdom be trying to alert you to something? YES NO

4. Do you believe your body's inherent wisdom has the ability to heal or significantly improve your present health challenges? YES NO

5. What do you believe to be the key areas that you must more effectively address in order to access more of your healing potential? diet exercise rest relaxation attitude addictive behaviors
 occupation stress reduction nutritional supplementation

6. Do you take regular, deliberate actions to improve and/or sustain your health? YES NO

If no, have you ever done so? YES NO. If yes, how specifically did you do so and why did you stop?

7. What will it take to increase your level of interest and action with respect to healthy activities?

8. What do you perceive your role or responsibility is with respect to your healthcare?

9. What do you perceive my responsibility is with respect to your healthcare? How do you believe I may best assist you in attaining better health?

10. Rate your present level of commitment to learn and implement the healthy changes that will improve your health and well-being? (1 being least committed to 10 being most committed) _____

If less than 8, what will it take to increase your level of commitment?



Dr. William J. Rice, DC, DACBN, LAc, FACCN

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to Dr. William J. Rice and Wholistic Health Center, Inc. to use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the practice's diagnosis or treatment of me may be conditioned upon by my consent as evidenced by my signature on this document.

For purposes of this consent, PHI means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health condition; the provision of health care to me; or past, present, or future payment for the provision of health care services to me; and that either indemnifies me from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment of healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance to this consent.

Signature of Patient or Guardian

Name of Patient or Guardian

Date

Description of Guardian