

Whom may we thank for referring you to this office _____?

APPLICATION FOR CARE AT THRIVE WELLNESS CENTER

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Current or Past Military: Yes No If so, which branch of the military? _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children & Age: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the numbers:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Secondary complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It's constant OR It's on and off during the day OR It comes and goes throughout the week

How did this injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes If yes, when: _____ By whom: _____

How long were you under care: _____ What were the results: _____

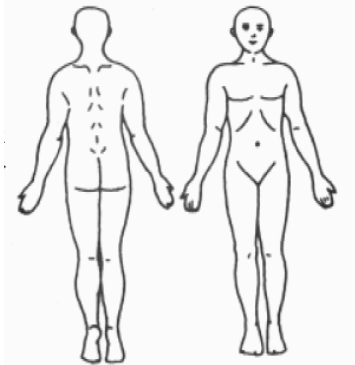
Name of Previous Chiropractor: _____ N/A

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? Yes No



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
<i>Example: Sitting</i>	<i>I can only sit for 10 minutes</i>	<i>I can't sit as long as I want too</i>
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? Yes No **If yes** how many times? _____
 When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried? Yes No **If yes**, please state what type? _____
 Who provided it: _____ **How long ago:** _____
 What were the results? Favorable Unfavorable **Please explain:** _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

____ Broken Bone ____ Dislocations ____ Tumors ____ Rheumatoid Arthritis ____ Fracture ____ Disability ____ Cancer
 ____ Heart Attack ____ Osteoarthritis ____ Diabetes ____ Cerebral Vascular ____ Other serious conditions:

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem(s):

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES		
SURGERIES		
CHILDHOOD DISEASES		
ADULT DISEASES		

SOCIAL HISTORY

- Smoking:** Cigars Pipe Cigarettes : **How often?** Daily Weekends Occasionally Never
- Alcoholic Beverage:** consumption occurs : Daily Weekends Occasionally Never
- Recreational Drug use:**
- Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect the following. See pg 3: (Activities of Daily Living)

FAMILY HISTORY

- Does anyone in your family suffer with the same condition(s)? Yes No
 If yes, whom: Grandmother Grandfather Mother Father Son(s) Daughter(s) Sister(s) Brother(s)
 Have they ever been treated for their condition? Yes No I don't know
- Any other hereditary condition(s) the doctor should be aware of? No Yes: _____

I hereby authorize payment to be made directly to Thrive Wellness Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thrive Wellness Center for any and all services I receive at this office.

Patient of Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Received

Patient's Name: _____ **HR#:** _____ / / _____ **JDD, DC 2/2012**

ACTIVITIES OF DAILY LIVING / SYMPTOMS / MEDICATIONS

Patient Name: _____
 Date: _____

File#: _____

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition(s) is/are affecting you ability to carry out activities that are routinely part of your life.

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreational Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting or Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Please mark **P** for in the **Past**, **C** for **Currently Have** and **N** for **Never**

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence or Sexual Dysfunction | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back pain | <input type="checkbox"/> Pain while Coughing or Sneezing | <input type="checkbox"/> Ringing in Ear(s) | <input type="checkbox"/> Menopausal Problem | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back pain | <input type="checkbox"/> Foot / Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problem |
| <input type="checkbox"/> Back curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Problem |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Numbness/Tingling in Arms, Hands, Fingers | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> Numbness/Tingling in Legs, Feet, Toes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping or Sleep Apnea | <input type="checkbox"/> Hepatitis (A,B,C) | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> High Cholesterol |

TRAUMA HISTORY

1. When was your most recent auto accident? _____
What speed was the collision? _____
Type of impact: Front impact / Side impact / Rear impact
Was treatment(s) received? Please describe: _____
2. When was your most recent strain / sprain / stress at work? _____
Please describe the manner of the injury: _____
Was treatment(s) received? Please describe: _____
Does your job require you to remain in long term stressful postures? _____
(i.e. all day sitting, repeated lifting, long term computer use)

List Prescription & Non-Prescription drug(s) you take:

Doctor's Signature: _____

Date: _____

JDD, DC 2/2012

NOTICE OF PRIVACY PRACTICE

This office is required to notify you, in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or **as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copied in report folders labeled '**HIPPA**' on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your **PHI**

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailing to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge via email, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like to have a disc of your images made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Thrive Wellness Center at (507) 258-4100. If we are unavailable, you may make an appointment with our office manager to discuss the concerns within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

Patient's initials: _____

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my right or any of the information I have received.

Patient's Name **DOB** **HR#**

Patient's Signature **Date**

Witness **Date**

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefit I have), I am ultimately responsible to pay Thrive Wellness Center, PA, Pratt Family Chiropractic, LLC, Dr. Nicholas Pratt, Dr. Francis Ngwa, Kyle Tooley, PA, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, test, or medications provided.

I hereby authorize payment of, and assign my right to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been or will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal right under, or pursuant to, any health plan (including, but not limited to, an ERISA plan, PPACA plan, or insurance contract) right that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family member as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20_____.

X _____
(patient signature)

_____ (please print patient name)

X _____
(signature of Guardian if applicable)

THRIVE WELLNESS CENTER'S INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Thrive Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature

Date

Witness' Initials

X-RAYS/IMAGING STUDIES

FEMALES ONLY: please read carefully and check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

The first day of my last menstrual cycle was on ____ / ____ / ____ date.

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do hereby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature

Date

Witness' Initials

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any conditions other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: _____ I have read and understand the above consent form