CARLYLE WELLNESS

THE ROAD TO WELLNESS STARTS HERE

(Please Print)

PATIENT INFORMATION					
Patient's name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Widow	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security Number	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		City:		State:	
Zip Code	Home Phone:	Cell Phone:	Work Phone:		
Occupation:	Employer:	Email Address			
Chose clinic because/Referred to clinic by (please check one box): _____ ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow ❑ Insurance Plan					

Spouse's Name: _____

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

Purpose of this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)? ❑ Yes ❑ No

If yes, when did this happen: _____

Describe:

_____

Please use the General Symptoms Chart on next page to provide a detailed notation of your symptoms

When did Symptoms begin? _____/_____/_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity Related

Are the symptoms getting worse ❑ Yes ❑ No Do they interfere with ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

If yes, please explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes explain: _____

Have you experienced these symptoms before? ❑ Yes ❑ No If yes explain: _____

Have you been treated for this before? ❑ Yes ❑ No If yes, when were you last treated _____/_____/_____

Who did you see_____

What treatment was preformed_____

How did you respond_____

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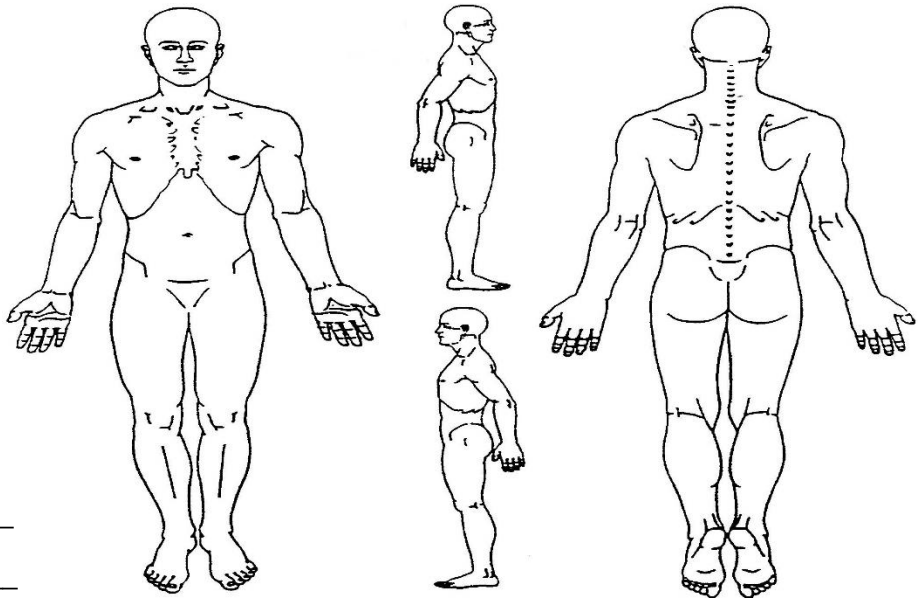
General Symptoms Chart
Please Mark the areas on the Diagram with the Following letter to describe your symptoms

R= Radiating
B= Burning
D= Dull
A= Aching
N= Numbness
S= Sharp/Stabbing
T= Tingling
O= Other

If you marked 'O" for any part
Please explain: _____

_____



HEALTH & LIFESTYLE

Do you exercise? ❑ Yes ❑ No How often? _____day(s) per week

What activities ❑ Walking ❑ Running ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other

Do you smoke? ❑ Yes ❑ No How much/how often? _____

Do you drink alcohol? ❑ Yes ❑ No How much/how often? _____

Do you drink coffee? ❑ Yes ❑ No How much/how often? _____

Do you take any supplements (i.e. Vitamins, minerals, herbs? ❑ Yes ❑ No

If so please list_____

Please list any surgeries (include type of surgery and date it was preformed)

_____

_____

INSURANCE INFORMATION

Primary Insurance
Company_____ Policy ID #_____

Insured's Name_____ Relationship to insured_____

Insured's Social Security Number_____/_____/_____ Insured's date of birth_____/_____/_____

Secondary Insurance
Company_____ Policy ID #_____

Insured's Name_____ Relationship to insured_____

Insured's Social Security Number_____/_____/_____ Insured's date of birth_____/_____/_____

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DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier, they are providing that service strictly as a convenience to me. The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance does not cover
If this is the case are you willing to pay for these services ❑ Yes ❑ No

Patient's Signature_____ Today's Date _____/_____/_____

Signature of person authorizing care (if different from the Patient)

_____ Today's Date _____/_____/_____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the resident doctor and his associates have my permission to preform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle _____/_____/_____

AUTHORIZATION FOR CARE

I authorize and agree to allow the doctor and /or his designated staff to work with my spine or the spine of the patient I represent, through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I understand that I am responsible for a health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the Doctor and or his staff's specific recommendations at the clinic that I will not receive the full benefit from these programs and that if I terminate my care prematurely tat all fees incurred will be due and payable at that time.

Patient's Signature_____ Today's Date _____/_____/_____

Patient's Printed Name_____

If Patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded: _____/_____/_____ County, State of Guardianship_____

I hereby authorize the Doctor to administer care as deemed necessary to my charge as appointed to me by the courts.

Guardian Signature: _____ Today's Date _____/_____/_____

IN CASE OF EMERGENCY

Name: _____ Relationship_____

Work Phone: _____ Home Phone: _____ Cell Phone: _____