PARAGON WELLNESS CENTER

RECLAIM YOUR HEALTH. REVIVE YOUR LIFE.

_____
Patient Number
(Office Use Only)

PLEASE NOTE:

This file must be saved to your desktop before and after completing!

PATIENT INFORMATION

Date _____ First Name _____ Middle Name _____ Last Name _____

SSN _____ Sex _____ Birth Date _____ Height _____ Weight _____

Marital Status _____ Spouse Name _____ Number of Children _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Emergency Contact _____

Emergency Relation _____ Emergency Phone _____

EMPLOYER INFORMATION

Employed? ☐ Yes ☐ No

Employer Name: _____

Occupation: _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Primary ID/Policy _____ Primary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Secondary ID/Policy _____ Secondary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

REFERRAL INFORMATION

I was referred by _____

_____
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Where did you hear about us?

☐ Advertisement ☐ Internet ☐ Community Event ☐ Family/Friend ☐ Other _____

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? _____

Did something trigger your health changes?

Primary Care Provider:_____ Provider's Phone Number:_____

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: _____

Condition

_____
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Describe your condition: _____

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _____ At its worst? _____ Now? _____

Type of injury, if applicable _____

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other _____

Condition Onset Date _____ Have you missed work related to this condition? ◯ Yes ◯ No

Unable to work from (dates) _____ to _____

Received other treatment for this? ◯ Yes ◯ No When and by whom? _____

X-rays taken? ◯ Yes ◯ No Do you currently receive chiropractic care? ◯ Yes ◯ No

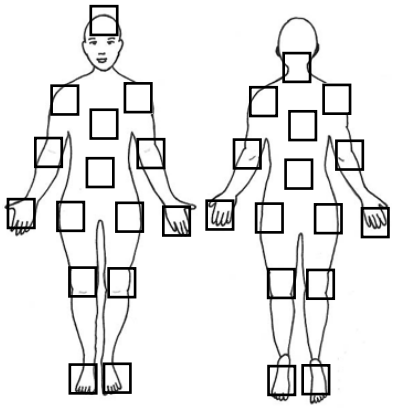
What clinic or chiropractor provides that care? _____

Did you receive chiropractic care in the past? ☐ Yes ☐ No If yes, when and where? _____

Please check the character of your current pain (you may check more than one):

Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Soreness ☐ Stiffness ☐ Weakness ☐

Throbbing ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐



Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: _____

How often are your symptoms present?

Constant ☐ Frequent ☐ Occasional ☐ Intermittent ☐

Since your problem began, is the pain? Increasing ☐ Decreasing ☐ No Change ☐

What activities make symptoms BETTER? Sitting ☐ Standing ☐ Laying Down ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

What activities make symptoms WORSE? Sitting ☐ Standing ☐ Coughing/Sneezing ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

Tobacco/Alcohol

Currently using tobacco? ◯ Yes ◯ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ◯ Yes ◯ No

If yes, explain: _____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ◯ Yes ◯ No If yes, was it: ◯ Mild ◯ Moderate ◯ High

Allergies

_____
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I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

I am allergic to the following environmental allergens:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Health History

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Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox	☐	☐
Measles	☐	☐
Mumps	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Chronic Fatigue Syndrome	☐	☐
Crohn's Disease or Ulcerative Colitis	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy, convulsions	☐	☐
Gallstones	☐	☐
Gout	☐	☐
Heart attack/Angina	☐	☐
Heart failure	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Irritable bowel	☐	☐
Kidney stones	☐	☐
Mononucleosis	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Sinusitis	☐	☐
Sleep Apnea	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Other (describe)		

Injuries	Yes	No
Head Injury	☐	☐
Neck Injury	☐	☐
Back Injury	☐	☐
Fracture	☐	☐
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray	☐	☐	
Mammogram	☐	☐	
EKG	☐	☐	
Colonoscopy	☐	☐	
Upper GI Series	☐	☐	
Barium Enema	☐	☐	
CAT scan of abdomen	☐	☐	
CAT scan of brain	☐	☐	
CAT scan of spine	☐	☐	
Liver scan	☐	☐	
Bone scan	☐	☐	
Neck X-rays	☐	☐	
Back X-rays	☐	☐	
MRI	☐	☐	
Bone Density Test	☐	☐	
Blood Tests	☐	☐	
Other (describe)			

Operations	Yes	No
Tonsillectomy	☐	☐
Tubes in Ears	☐	☐
Appendectomy	☐	☐
Gall Bladder	☐	☐
Hernia	☐	☐
Hysterectomy	☐	☐
Dental Surgery	☐	☐
Other (describe)		

Hospitalizations	
When	For What Reason

Women Specific

_____
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Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____ Are you currently pregnant? Yes ☐ No ☐

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ○ Yes ○ No Clotting? ○ Yes ○ No Have you ever missed your period? ○ Yes ○ No

For how long? _____ Are you menopausal? ○ Yes ○ No Age At Menopause _____

Last Menstrual Period _____

Do you take any form of birth control? ☐ YES ☐ NO

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

FOR ALL PATIENTS

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials:_____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials:_____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

Initials:_____

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials:_____

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials:_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials:_____

I grant permission for Paragon Wellness Center to charge my credit or debit card saved on file for services rendered in the event that verbal confirmation is not given or payment cannot be collected at the time of service.

Initials:_____

I acknowledge that any exam reservation deposit of $25 will be forfeited if I fail to give more than 24-hour notice to cancel my appointment, or arrive later than my scheduled arrival time and should need to be rescheduled as a result.

Initials:_____

Please email this completed form to **info@paragondrs.com**

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

Signature _____ Date _____

Thank you!

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to a Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician of Paragon Wellness Center. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

I understand that if I am accepted as a patient by a physician at Paragon Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Name: _____

Patient Signature: _____ Date: _____

If patient is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian (circle one) _____ Date: _____

Witness: _____ Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____ Date_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____ Date_____
Signature of Parent/Guardian (circle one)

Please list below anyone you would like to have access to your protected health information (PHI).

	Name	Relation	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Re: Assignment of Insurance Benefits/Authorization for Payment

Patient: _____

Employer: _____

Claim/Group#: _____

Insurance ID# and Date of Birth: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Dr. Lloyd Dane Ericson, DC
Paragon Wellness Center
1332 W. Arch Haven Ave. Ste. C
Bloomington, IN 47403

Tel: (812) 333-7447
Fax: (812) 333-7442
Email: https://paragondrs.com

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

_____ c/o Dr. Lloyd Dane Ericson

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Insured's Signature: _____ Date: _____

If Insured is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian (circle one) _____ Date: _____

Witness: _____ Date: _____