

PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ SS# _____
Birth Date ___/___/___ Age _____ Sex _____
 Married Single Divorced Widowed
Whom may we thank for referring you? _____
What name do you prefer to be called? _____
May we use your email for blog updates and appt reminders? Yes No
Email _____

EMPLOYMENT INFO

Occupation _____
Employer _____
Address _____
Phone # _____

INSURED INFO

Insured Name _____
Relationship _____
DOB _____

Who is responsible for your bill, You and:

Spouse Health Insurance Workers' Comp. Auto Insurance Medicare

Previous chiropractic care: None Doctor's name & approximate date of last visit _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

When did the symptoms first appear? _____

[Mark your areas of concern on figure]

Has this condition occurred before? Yes No

How often do you experience the symptoms?

Constant 100% Frequent 75%
 Intermittent 50% Occasional 25% Rare 10%

What makes the symptoms worse? _____

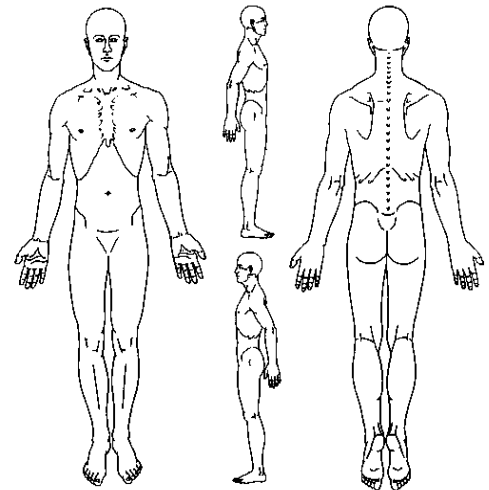
What relieves the symptoms? _____

How would you describe the pain?

Sharp Dull Aching Burning Numb
 Throbbing Radiating Deep Other _____

Rate the pain on a scale of 1-10 (10 being unbearable pain):

Right Now 1---2---3---4---5---6---7---8---9---10
At Its Worst 1---2---3---4---5---6---7---8---9---10



Other Doctors Seen For This Condition: Yes No Who? _____

Type of treatment? _____ Results? _____

Is this condition: Job Related Auto Accident Home Injury Fall Other: _____

Do you wear a shoe lift? Yes No

Do you suffer from any condition other than for that which you are now consulting us?

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 HAD

- | | | | | |
|--------------------------------|---------------------------------|--------------------------------|--|---------------------------------------|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Gout | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Anemia | <input type="radio"/> Cancer | <input type="radio"/> Epilepsy | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Rheumatic Fever |

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

- | | | | |
|---|---|---|---|
| <i>Musculoskeletal Code</i> | <i>General Code</i> | <i>C-V-R Code</i> | <i>Genitourinary Code</i> |
| <input type="radio"/> General Stiffness | <input type="radio"/> Fatigue | <input type="radio"/> Chest Pain | <input type="radio"/> Bladder Trouble |
| <input type="radio"/> General Weakness | <input type="radio"/> Allergies | <input type="radio"/> Short Breath | <input type="radio"/> Painful/Excessive Urine |
| <input type="radio"/> Swollen Joints | <input type="radio"/> Headache | <input type="radio"/> Asthma | <input type="radio"/> Discolored Urine |
| <input type="radio"/> Spinal Curvature | <input type="radio"/> Loss of Sleep | <input type="radio"/> Blood Pressure Problems | |
| <input type="radio"/> Neck Pain | <input type="radio"/> Weight Loss | <input type="radio"/> Irregular Heartbeat | <i>For Women Only</i> |
| <input type="radio"/> Arm Pain | <input type="radio"/> Fever | <input type="radio"/> Heart Problems | <input type="radio"/> Cramps |
| <input type="radio"/> Pain Between Shoulders | <input type="radio"/> Thyroid Problems | <input type="radio"/> Lung Problems | <input type="radio"/> Irregular Cycle |
| <input type="radio"/> Low Back Pain | <i>Gastrointestinal Code</i> | <input type="radio"/> Varicose Veins | <input type="radio"/> Painful Periods |
| <input type="radio"/> Foot Trouble | <input type="radio"/> Poor/Excessive Appetite | <input type="radio"/> Ankle Swelling | <input type="radio"/> Pregnant (now) |
| <input type="radio"/> Walking Problems | <input type="radio"/> Excessive Thirst | <input type="radio"/> Stroke | |
| <input type="radio"/> Jaw Problems | <input type="radio"/> Vomiting | <i>EENT Code</i> | <i>Family History</i> |
| <i>Nervous System Code</i> | <input type="radio"/> Nausea | <input type="radio"/> Vision Problems | The following members |
| <input type="radio"/> Nervous | <input type="radio"/> Diarrhea | <input type="radio"/> Dental Problems | have a same or similar |
| <input type="radio"/> Numbness | <input type="radio"/> Constipation | <input type="radio"/> Sore Throat | problem as I do: |
| <input type="radio"/> Dizziness | <input type="radio"/> Liver Problems | <input type="radio"/> Ear Aches | <input type="radio"/> Father |
| <input type="radio"/> Forgetfulness | <input type="radio"/> Gall Bladder Problems | <input type="radio"/> Hearing Difficulty | <input type="radio"/> Mother |
| <input type="radio"/> Depression | <input type="radio"/> Abdominal Cramps | <input type="radio"/> Stuffed Nose | <input type="radio"/> Brother |
| <input type="radio"/> Cold/Tingling Extremities | <input type="radio"/> Gas/Bloating/Belching | <input type="radio"/> Frequent Colds | <input type="radio"/> Sister |
| <input type="radio"/> Stress | <input type="radio"/> Heartburn | <input type="radio"/> Nose Bleeds | <input type="radio"/> Child |
| <input type="radio"/> Twitching | <input type="radio"/> Black/Bloody Stools | <input type="radio"/> Sinus Trouble | <input type="radio"/> Other _____ |
| | <input type="radio"/> Colitis | <input type="radio"/> Hoarseness | |

HEALTH HABITS

Exercise/Sports/Hobbies:

- 1) Type _____ Frequency _____ 2) Type _____ Frequency _____
 3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep: Hours/night ____ Sleep quality _____ Do you sleep on your: Back Side Stomach

Smoking/Drinking/Diet: (how much and how often)

Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

OCCUPATIONAL INFORMATION

Job involves: Sitting Standing How long? _____

Bending Stooping Twisting Turning Lifting - How much weight? _____

Physical activity at work: Sedentary Light manual labor Heavy labor

Telephone use at work: None Moderate Heavy Traditional receiver Headset

Do any work activities aggravate your complaints? _____

PAST HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ When _____

Type _____ When _____

Type _____ When _____

Please list ALL previous accidents and falls

What _____ When _____

What _____ When _____

What _____ When _____

Please list ALL medications and/or vitamins you take

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT

Cash

Check

Credit/Debit

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

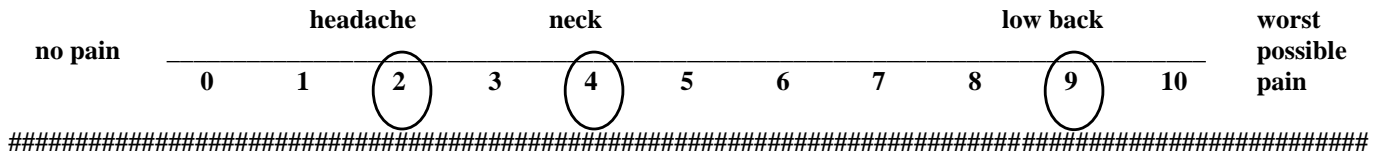
Doctor's Signature _____

QUADRUPLE VISUAL ANALOGUE SCALE

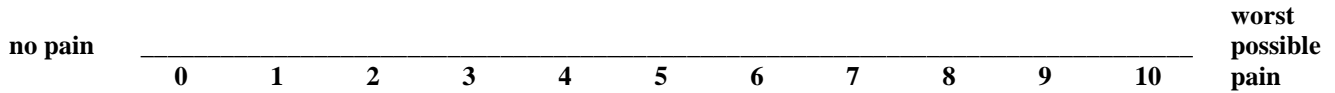
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

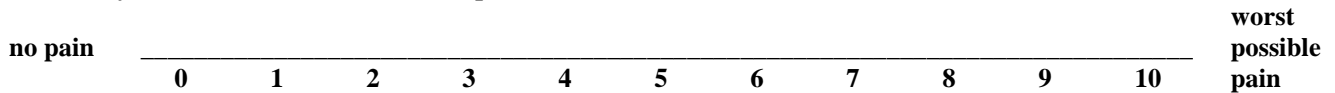
EXAMPLE:



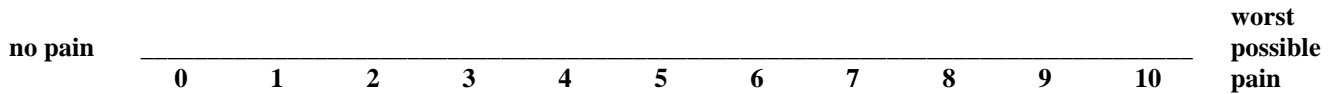
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

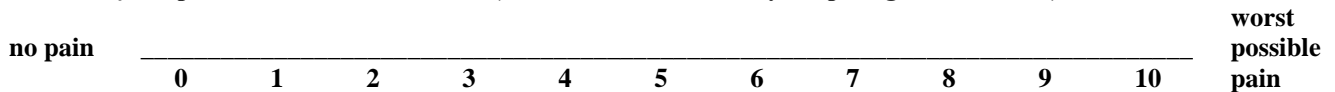


3. What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

NAME _____ **AGE** _____ **DATE** _____

SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No
pain

Mild
pain

Moderate
pain

Severe
pain

Worst
possible
pain

2. Sleeping

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

Perfect
sleep

Mildly
disturbed
sleep

Moderately
disturbed
sleep

Greatly
disturbed
sleep

Totally
disturbed
sleep

3. Personal Care (washing, dressing, etc.)

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain;
No restrictions

Mild pain;
no restrictions

Moderate pain;
need to go slowly

Moderate pain;
need some
assistance

Severe pain;
need 100%
assistance

4. Travel (driving, etc.)

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain on
long trips

Mild pain on
long trips

Moderate pain
on long trips

Moderate pain
on short trips

Severe pain
on short trips

5. Work

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

Can do usual work
plus unlimited
extra work

Can do usual
work; no extra
work

Can do 50% of
usual work

Can do 25% of
usual work

Cannot work

6. Recreation

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

Can do all activities

Can do most activities

Can do some activities

Can do a few activities

Cannot do any activities

7. Frequency of pain

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain

Occasional pain;
25% of the day

Intermittent pain;
50% of the day

Frequent pain;
75% of the day

Constant pain;
100% of the day

8. Lifting

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain with heavy weight

Increased pain with heavy weight

Increased pain with moderate weight

Increased pain with light weight

Increased pain with any weight

9. Walking

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain; any distance

Increased pain after 1 mile

Increased pain after 1/2 mile

Increased pain after 1/4 mile

Increased pain with all walking

10. Standing

| 0 _____ | 1 _____ | 2 _____ | 3 _____ | 4

No pain after several hours

Increased pain after several hours

Increased pain after 1 hour

Increased pain after 1/2 hour

Increased pain with any standing

Patient's Signature

Date

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a natural wellness facility we have one main goal, to detect and correct/reduce health challenges. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of postural abnormality. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Postural Abnormality: A misalignment of one or more regions of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than Postural abnormality. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct postural abnormality combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to the Natural Wellness & Pain Relief Centers of Michigan for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of the Natural Wellness & Pain Relief Centers of Michigan to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature _____

Date _____ (If under age 18) Parent's signature

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an “article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient’s diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at *Natural Wellness & Pain Relief Centers of Michigan*

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____,

have read and understand the above statement on _____ (date),

witnessed by _____, _____ (date).

10683 S Saginaw St
Suite B
Grand Blanc, MI 48439
(810) 694-3576

51145 Washington St
Suite E
New Baltimore, MI 48047
(586) 716-8493



NATURAL WELLNESS & PAIN RELIEF CENTERS OF MICHIGAN

Functional Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your conventional medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

I have read and understand the above:

Signature

Date

Witness

Date

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Suite B
Grand Blanc, MI 48439
(810) 694-3576

51145 Washington St
Suite E
New Baltimore, MI 48047
(586) 716-8493



Authorization for Assignment of Benefits

While Dr. Megan Strauchman and/or Dr. Mark Morningstar is waiting for payment for all of the fees, I agree to provide the office with information and forms regarding any source of potential payment, to assist in any way I can, and:

1. I hereby assign to Dr. Megan Strauchman and/or Dr. Mark Morningstar my rights to receive payments from negligent parties or from insurance companies responsible for my claim.
2. I hereby authorize the direct payment to Dr. Megan Strauchman and/or Dr. Mark Morningstar of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. You are authorized to release any information including the diagnosis and records of any such treatment to any insurance company, attorney or claims adjustor to process any claim for reimbursement of charges incurred.
4. I hereby assign and transfer to you the cause of action that exists in my favor, including the right to proceed via AAA Arbitration or Superior Court, against the insurance company or third party responsible for this claim to collect any unpaid bills. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

Print Name

Date

Signature

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Strauchman-Morningstar Advanced Healthcare, PLC, also known as the Natural Wellness & Pain Relief Centers of Michigan, "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Strauchman-Morningstar Advanced Healthcare, PLC / Natural Wellness & Pain Relief Centers of Michigan. The Notice of Privacy Practices for is also provided on request at the main administration desk of this practice and on Strauchman-Morningstar Advanced Healthcare, PLC / Natural Wellness & Pain Relief Centers of Michigan's website at www.michiganwellnessandpainrelief.com. This Notice of Privacy Practices also describes my rights and our clinic's duties with respect to my protected health information.

Strauchman-Morningstar Advanced Healthcare, PLC / Natural Wellness & Pain Relief Centers of Michigan reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority