Therapy Center for Perinatal Wellness and Physical Therapy
8955 Guilford Road Suite 140
Columbia, MD 21046
Ph: (443) 542-2480
www.therapyhealthgroup.com

Adult
Wellness Profile

Practice Member Information: _____ File: _____
Appointment Date: _____
Name: _____ Birth date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ May we leave a message? ☐Yes ☐No
Cell Phone: _____ May we leave a message? ☐Yes ☐No
Work Phone: _____ May we leave a message? ☐Yes ☐No
Email: _____
May we add you to our email newsletter and calendar of events? ☐Yes ☐No (Your email will not be shared)
Spouse's Name: _____
Name(s) and age(s) of children: _____ _____ _____ _____
Occupation: _____
Do you primarily: ☐Sit ☐Stand ☐Perform repetitive tasks
How did you hear about us? _____

Healthcare History
Have you had previous chiropractic care? ☐Yes ☐No
If yes, who was your previous Chiropractor? _____
Where? _____ When? _____
Were X-rays taken in the last 6 months? ☐Yes ☐No
What was the primary reason for consulting that office?
☐Relief Care – Symptom relief of pain or discomfort
☐Corrective Care – Correcting, relieving and stabilizing spinal, joint and postural issues
☐Wellness Care – Maximizing the body's ability for optimal healing and function
Do you feel your chiropractic care was effective? ☐Yes ☐No
Please explain: _____
Are you wearing: ☐Heel Lifts ☐Custom Orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? ☐Yes ☐No
Naturopathic Doctor: _____
Date and reason of last visit: _____

Other Specialists and Healthcare Professionals:
Name: _____
Professional Designation: _____
Date and reason of last visit: _____
Name: _____
Professional Designation: _____
Date and reason of last visit: _____

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Do you have a specific concern that brings you in?
☐No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.
☐Yes _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____
How long have you been aware of this? _____days _____weeks _____months _____years
Where else does this pain go in your body? _____
How often do you experience this? ☐daily ☐weekly ☐monthly ☐comes and goes ☐constantly
On a scale of 1 to 10 (10 being the worst), how does it feel when it's at it worst? _____
How would you describe the pain/discomfort?
☐Dull ☐Achy ☐Throbbing ☐Stabbing ☐Tight/Stiff ☐Burning ☐Sharp ☐Other: _____
What makes it feel worse? _____
What makes it feel better? _____
Do you notice any other problems in your body when you get this pain/discomfort? _____
Do you feel your condition getting progressively worse? ☐Yes ☐No
Do you feel your condition can be healed? ☐Yes ☐No
What have you tried that ***has*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic
Other: _____
What have you tried that ***hasn't*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic
Other: _____

See additional ***Spinal Nerve Function Form (Page 5)*** to provide further detail on your *Wellness Profile*

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment of the spinal column as well as damage the delicate nervous system. The result is a condition called ***Vertebral Subluxation***. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height: _____ Weight: _____ Are you happy with your current physical appearance and abilities? ☐Yes ☐No
Frequency of exercise per week: Cardio: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Weight Bearing: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Do you stretch after exercise or after other activities of poor posture? ☐Yes ☐Sometimes ☐No
Hours of sleep at night: ☐<6 ☐7-9 ☐10+ Do you feel refreshed upon waking? ☐Always ☐Sometimes ☐Rarely
Age of mattress: _____ Do you feel your mattress is appropriate for your sleeping style? ☐Yes ☐No
Sleep position: ☐Back ☐Belly Side: ☐Right ☐Left ☐Both
Number of hours spent commuting per week: ☐0-2 ☐3-5 ☐6-8 ☐9-11 ☐12+
Number of hours spent at a desk or computer per week: ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+
Number of hours spent on a smart device/tablet per week: ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+
Do you perform any repetitive tasks at home or at work? ☐Yes ☐No
Have you ever been hospitalized or had surgery? ☐Yes ☐No

Have you ever been in a motor vehicle accident (even if it was minor)? ☐Yes ☐No
If yes, what kind and when? _____
Were you evaluated and treated after each accident? ☐Yes ☐No
Have you had any non-vehicle accidents or falls? ☐No ☐Yes: _____

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Adult
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Early Years

To your knowledge was your delivery very difficult? ☐No ☐Yes
If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐Other: _____
Were you breast fed? ☐No ☐Yes If yes, for how long? _____
Did you experience emotional trauma as a child? ☐No ☐Yes – explain: _____
Were you ever given antibiotics as a child? ☐No ☐Yes – list: _____
Did you ever have ear infections as a child? ☐No ☐Yes – how often: _____
Any major childhood illness? ☐No ☐Yes – list: _____

Emotional

Rate your current level of ***personal stress*** in your life ..... ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***relationship stress*** in your life..... ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***financial stress*** in your life ..... ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***health stress*** in your life..... ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***family stress*** in your life..... ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***career stress*** in your life..... ☐None ☐Low ☐Moderate ☐High
Do you feel you have a supportive network of friends and family?..... ☐Yes ☐No
Do you feel you have healthy coping strategies for life stress? ..... ☐Yes ☐No

Chemical

Were you vaccinated as a child? ..... ☐No ☐Yes
Any adverse reactions to vaccines?..... ☐No ☐Yes _____
Do you choose to have annual flu shots? ..... ☐No ☐Yes
Do you take antibiotics? ..... ☐No ☐Yes How often? _____
How many glasses of water per day:..... ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of caffeinated beverages per day: ..... ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice, and soda per day:..... ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Do you eat gluten?..... ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat dairy?..... ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread, and pasta)..... ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat boxed/frozen foods?..... ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ..... ☐No ☐Yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Do you consume any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc.).. ☐No ☐Yes
Any food/drink allergies, sensitivities, intolerances?..... ☐No ☐Yes _____
Do you smoke?..... ☐No ☐Yes ☐I used to for ____ years ☐I wish I didn't
Are you or have you been exposed to second hand smoke?..... ☐No ☐Yes
Do you drink alcohol? ..... ☐No Yes: ☐0-6/week ☐6-12/week ☐12+/week
Do you take a probiotic daily?..... ☐No ☐Yes
Do you take Vitamin D3 daily?..... ☐No ☐Yes
Do you take Omega 3 Fish Oils daily?..... ☐No ☐Yes
Other supplements or homeopathics: _____
Any other daily medication and their purpose? _____

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐No ☐Yes

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Adult

Wellness Profile

Family Health

At our clinic we are not only interested in your health and wellness, but also health and wellness of the important people in your life. Please mention below any health conditions or concerns you have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care – Symptom relief of pain or discomfort
- ☐ Corrective Care – Correcting, relieving, and stabilizing spinal, joint, and postural issues
- ☐ Wellness Care – Maximizing the body's ability for optimal healing and function of the nervous system

Do you have other concerns we should know about? _____

Goals & Consent

What is your primary goal for consulting with our clinic?

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference call subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I, _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan, and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date

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Review of Systems
Function of Spinal Nerves

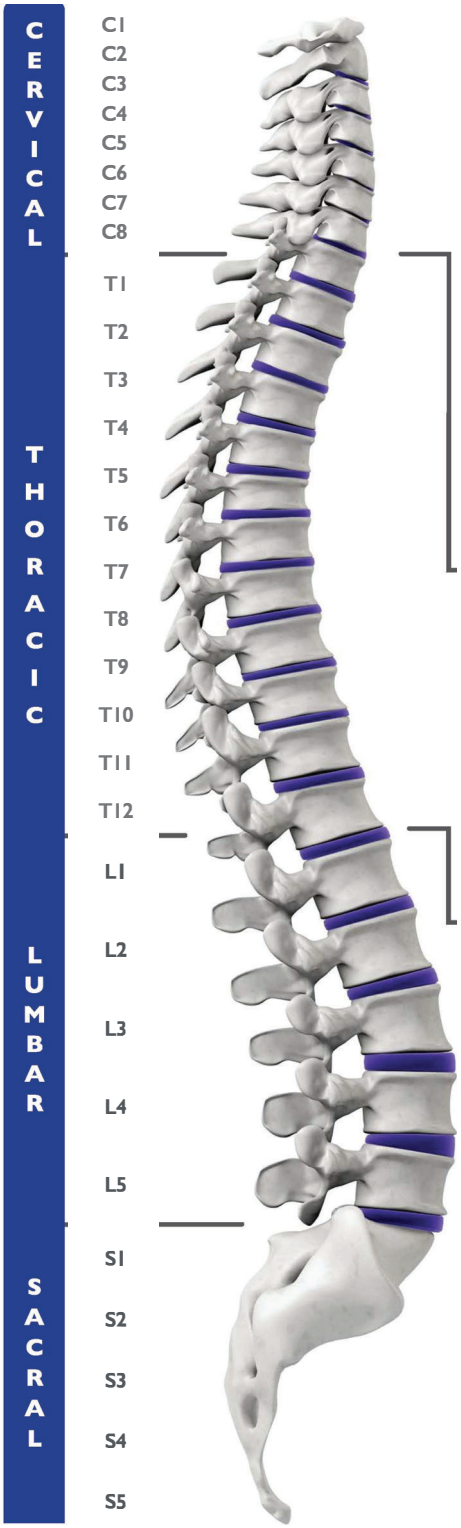
SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.



Parotid Gland • Scalp
Base of Skull • Eyes
Lacrimal Gland • Sinuses
Inner, Middle & Outer Ear
Nose • Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles • Diaphragm
Shoulders • Elbows • Arms
Wrists • Hands & Fingers
Tonsils • Vocal Cords
Esophagus • Heart
Lungs • Chest • Thyroid

Arms • Wrists
Esophagus • Chest • Heart
Lungs • Trachea • Larynx
Diaphragm • Stomach
Gallbladder • Liver
Pancreas • Small Intestine
Spleen • Kidneys • Appendix
Adrenals • Colon • Buttocks
Uterus • Ovaries • Testes

Large Intestine • Colon
Thighs • Buttocks • Groin
Knees • Legs • Feet
Reproductive Organs

Buttocks • Groin • Legs
Ankles • Feet • Toes
Prostate Gland • Bladder
Reproductive Organs

CURRENT	PREVIOUS	
☐	☐	Sinus & Ear Pain/Infection
☐	☐	Runny Nose & Allergies
☐	☐	Frequent Head Colds
☐	☐	Sore Throat & Tonsilitis
☐	☐	Strep Throat
☐	☐	Chronic Cough & Croup
☐	☐	Difficulty Breathing
☐	☐	Poor Immunity
☐	☐	Dizziness & Vertigo
☐	☐	Tinnitus & Ear Fullness
☐	☐	Vision Problems
☐	☐	Watery/Dry Eyes
☐	☐	Chronic Fatigue
☐	☐	Poor Concentration
☐	☐	Depression
☐	☐	Asthma
☐	☐	Bronchitis & Pneumonia
☐	☐	Congestion
☐	☐	Reflux & GERD
☐	☐	Indigestion & Heartburn
☐	☐	Stomach Pains
☐	☐	Ulcers
☐	☐	Gas & Bloating
☐	☐	Jaundice
☐	☐	Liver Conditions
☐	☐	Blood Sugar Dysregulation
☐	☐	Irritable Bowel, Colitis, Crohn's
☐	☐	Gas Pain & Constipation
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Bladder Infections
☐	☐	Bladder Incontinence & Bedwetting
☐	☐	Painful/Excessive Urination
☐	☐	Varicose Veins
☐	☐	Leg Cramping
☐	☐	Restless Legs
☐	☐	Poor Circulation & Cold Feet

CURRENT	PREVIOUS	
☐	☐	Anxiety & Stress
☐	☐	Seizures
☐	☐	ADD/ADHD
☐	☐	Thyroid Dysfunction
☐	☐	Metabolic Dysfunction
☐	☐	Insomnia
☐	☐	High/Low Blood Pressure
☐	☐	Enlarged Lymph Glands
☐	☐	Migraines & Headache
☐	☐	TMJ Pain
☐	☐	Stiff Neck
☐	☐	Arm Pain
☐	☐	Hand/Finger Numbness
☐	☐	Loss of Grip Strength
☐	☐	Kidney Stones
☐	☐	Gall Bladder Attacks
☐	☐	Skin Conditions & Rashes
☐	☐	Menstrual Cramps/PMS
☐	☐	Infertility
☐	☐	Menstrual Dysfunction
☐	☐	Rashes & Eczema
☐	☐	Hyperactivity
☐	☐	Shoulder Pain
☐	☐	Midback Pain
☐	☐	Rib Pain
☐	☐	Prostate Dysfunction & Impotence
☐	☐	Ovarian Cysts & Endometriosis
☐	☐	Fertility Problems/ Loss of Menstruation
☐	☐	Low Back Pain
☐	☐	Hip Pain
☐	☐	Thigh Pain
☐	☐	Numbness & Tingles in Legs
☐	☐	Sciatica
☐	☐	Pelvic Pain
☐	☐	Knee Pain
☐	☐	Ankle Pain & Sprains
☐	☐	Foot Pain & Weak Arches

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Center for Perinatal Wellness and Physical Therapy

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Work Ph. _____ Date of Birth _____ Social Security # _____

Employer _____ Address _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Company _____ Phone _____ Effective Date _____

Address _____ City _____ State _____ Zip Code _____

Policy Holder's Name _____ DOB _____ SSN _____

ID # _____ Group # _____

Secondary Insurance Company _____ Phone _____ Effective Date _____

Address _____ City _____ State _____ Zip Code _____

Policy Holder's Name _____ DOB _____ SSN _____

ID # _____ Group # _____

How did you learn about the Therapy Center for Perinatal Health and Wellness?

☐ I saw your sign. ☐ I was referred by Dr. _____ ☐ A friend or another patient referred me.

☐ Yellow Pages ☐ Promotional Coupon ☐ Other:_____

It is the policy of our office that all fees are due at the time services are rendered whether by check, cash or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees at the time of treatment in order to avoid any misunderstandings. We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account within the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient. I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical/medical equipment benefits to be made directly to Therapy Center for Perinatal Health and Wellness. After all insurance payments have been paid I fully understand that I am responsible for the remaining balance of my account.

Signature of Patient or Responsible Party: _____ **Date:** _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Therapy Center for Perinatal Health and Wellness 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, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, 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 rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights 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 behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members 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, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both 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, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20____.

X_____(SEAL)
(patient signature)

_____
(please print patient name)

X_____(SEAL)
(signature of Guardian if applicable)

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms for the following company: Therapy Center for Perinatal Health and Wellness.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Name as it Appears on Card/ACH Account

Email Address

Billing Address City State Zip Code

Phone Number

SIGNATURE DATE

Revised: 08-2021

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Center for Perinatal Wellness and Physical Therapy

Consent to Examination and Treatment

I hereby authorize Therapy Center for Perinatal Wellness and Physical Therapy and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide and evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate, I also wish to rely on the Therapy Center for Perinatal Wellness and Physical Therapy doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The naturs and purposed pf the chiropractic examination and evaluation, the adjustments, and other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

I have been advised that while although the incidence of complaications associated with chiropractic services, physical therapy, and other forms of treatment rendered is extremely low, anyone undergoing any kind of procedure should know of rare possible complications which may be encountered during the course of care. These include, but are not limited to fractures, disk injuries, dislocations, sprains, and those which related to aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the practice will advise me of any material risks in this regard.
2. The neither the practice of chiropractic or medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment may be recorded for the purposes of marketing and social media.

I understand this consent and have asked any questions pertaining to the consent and understand to my satisfaction the care and treatment I may receive. My signature below acnkowledges my consent to the examination, evaluation and proposed course of care and treatment by the practice.

Name

Email Address

Address City State Zip Code

Phone Number

SIGNATURE _____ DATE _____

Revised: 08-2021