Anderson Wellness Center
131 Buford Ave. Anderson, SC 29621

Kristen Geles-Steely DC
864-226-7676(Office) 864-226-7770(Fax)

Is this visit today due to Auto or Work Related Injuries? O No O Yes
If yes, when did this injury occur ___/___/______

Today's Date: ___/___/______

First Name: ____________ Middle Initial: ______ Last Name: ____________

Address: ____________ City: ____________ State: ______ Zip: ____________

Nickname: ____________ SS#: ____________

Home Phone: (____)__________ Work Phone: (____)__________ Cell Phone: (____)__________

Email address: ____________

It's Best to reach me by - O home phone O work phone O e-mail O cell phone ____________

Emergency Contact & Number____________ Primary Care Provider ____________

Marital Status: O Single O Married O Divorced O Separated O Widowed Date of Birth: ___/___/___

Spouse's Name ____________ Childs Name/Age ____________ Childs Name/Age ____________

Childs Name/Age ____________ Childs Name/Age ____________ Childs Name/Age ____________

Employment Status: O Full Time O Part Time O Retired O Other

Employer: ____________ Length of employment: ____________

Student Status: O Full Time O Part Time School ____________

Who may we thank for referring you to our office ____________
O Friend O Co-Worker O Yellow Pages O Internet O Other ____________

Main Complaint: (1)____________

Additional Complaint (2)____________

Additional Complaint (3)____________

Additional Complaint (4)____________

Additional Complaint(s) ____________

____

Have you been to a chiropractor before? ________ **if yes, date of approximate last visit** ____________

Patient ID # ____________

Activities of Daily Living

Does your condition currently interfere With any of the following activities	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O	Grocery Shopping	O	O	O	O
Rising out of a chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching overhead	O	O	O	O
Laying down	O	O	O	O	Showering of bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Climbing Stairs	O	O	O	O	Love Life	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of a car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Looking over shoulder	O	O	O	O	Exercising	O	O	O	O
Caring for family	O	O	O	O	Yard Work	O	O	O	O

Other limited activities not listed ___________________________

Medications

MEDICATIONS: Are you currently taking any of the listed medication?

O ADVAIR DISKUS
O ALBUTEROL
O ALEVE
O ALLEGRA
O ALPRAZOLAM
O AMBIEN
O AMITRIPTYLINE
O AMOX TR-POTASSIUM
O ATIVAN
O BENICAR
O CLAVULANA
O AMOXICILLIN
O ATENOLOL
O CELEBREX
O CEPHALEXIN
O CONCERTA
O CYMBALTA
O DARVOCET
O EFFEXOR XR
O EBMREL
O FEMHRT
O FLONASE
O FLUOXETINE HCL
O FOSAMAX
O FUROSEMIDE
O GABAPENTIN
O HRT IMIPRAMINE
O HYDROCHLOROTHIAZIDE
O IBUPROFEN
O LEVAQUIN
O LEVOTHYROXINE SODIUM
O LEVOXYL
O LEXAPRO
O LIDOCAIN
O LIPITOR
O LISINOPRIL
O LISINOPRIL-HCTZ
O LORTAB
O LOTREL
O LYRICA
O METFORMIN HCL
O METOPROLOL TARTRATE
O NAPROXEN
O NEXIUM
O NORVASC
O ORTHO EVRA
O PAMELOR
O PERCOCET
O PLAVIX
O PREDNISONE
O PREMARIN
O PREVACID
O PROPOXYPHENE NAPSYLATE
O PROTONIX
O PROZAC
O RANITIDINE HCL
O SINGULAIR
O SOMA
O SYNTHROID
O TOPROL XL
O TRIAMTERENE W/HCTZ
O ULTRAM
O WELLBUTRIN XL
O XANAX
O YASMIN 28
O ZETIA
O ZITHROMAX
O ZOCOR
O ZOLOFT
O ZYRTEC

List any other medications you are currently taking ___________________________

Illnesses

Had	Have		Had	Have				Other Conditions
O	O	AIDS	O	O	Glaucoma	O	O	Artificial Bones/Joints
O	O	Anemia	O	O	Heart Disease	O	O	Chemotherapy
O	O	Anemia	O	O	Hepatitis	O	O	Constipation
O	O	Alcohol / Drug Abuse	O	O	High Cholesterol	O	O	Diarrhea
O	O	Allergies____________	O	O	HIV	O	O	Difficulty Breathing
O	O	Arteriosclerosis	O	O	Kidney Problems	O	O	Fatigue
O	O	Arthritis	O	O	Malaria	O	O	Food Sensitivity
O	O	Asthma	O	O	Polio	O	O	Headaches
O	O	Blood Pressure O High O Low	O	O	Rheumatic Fever	O	O	Low Back Pain
O	O	Cancer	O	O	Scarlet Fever	O	O	Neck Pain
O	O	Chicken Pox	O	O	Sexual transmitted disease	O	O	Sinus Problems
O	O	Congenital Heart Defect	O	O	Shingles	O	O	Thyroid Issues
O	O	Depression	O	O	Stroke			
O	O	Diabetes	O	O	Tuberculosis			
O	O	Epilepsy	O	O	Ulcer			

Family History

Relative	Age (if living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	______	O	O	____________	______	O	O
Father	______	O	O	____________	______	O	O
Sister 1	______	O	O	____________	______	O	O
Sister 2	______	O	O	____________	______	O	O
Brother 1	______	O	O	____________	______	O	O
Brother 2	______	O	O	____________	______	O	O

Personal History

Previous surgeries and dates:

____

____

____

Previous Accidents/Injuries/Falls:

____

____

____

Alcohol use: ODaily OWeekly How much _____

Tobacco use: ONever OFormer OCurrent If Yes how much _____ O Cigarettes OPack (s) per day

Coffee/Caffeine use: ONo OYes **Per Day** O <3 cups; O 3-6 cups; O >6 cups

Occupational History

Job Activities: OStanding OSitting OTyping OHeavy Lifting OWalking O Other ______________________

Acknowledgements

Initials: ______ 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 this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

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

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

Initials: ______ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails of 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 carrier and me and that I am responsible for the payment of any covered of non-covered services I receive.

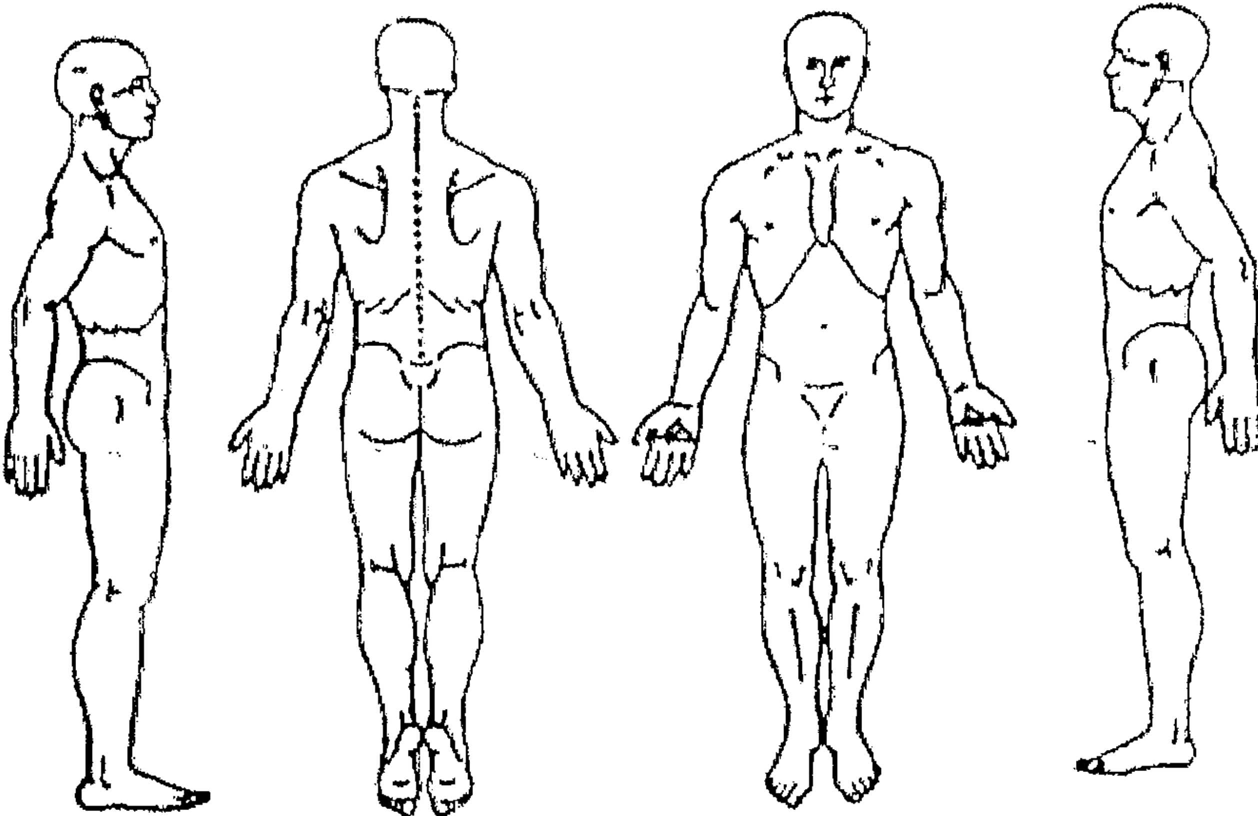
Initials: ______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or my health concern.

If the patient is a minor, print child's full name ______________________________

______________________________ Signature

______________ Date

PLEASE CIRCLE WHERE YOU ARE HURTING.

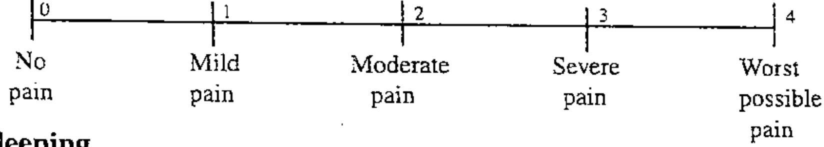


Functional Rating Index

For use with **Neck and/or Back Problems** only.

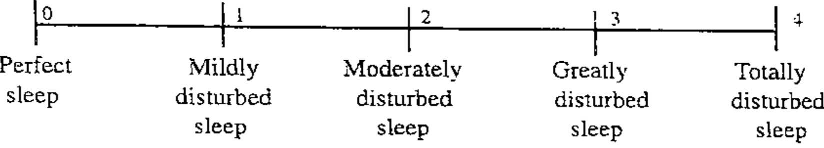
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



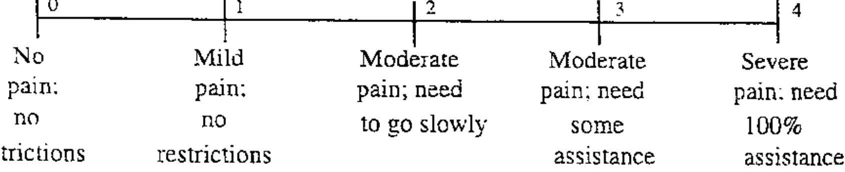
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



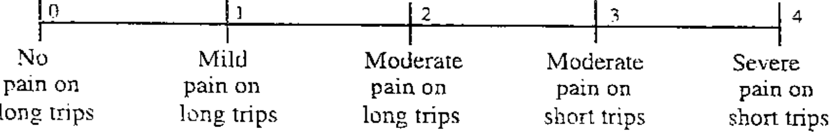
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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



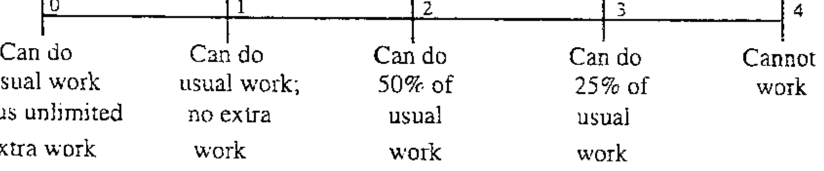
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



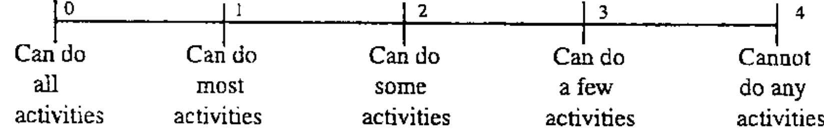
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



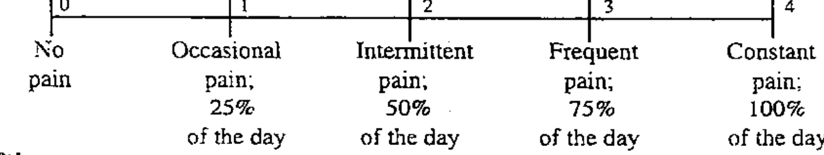
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



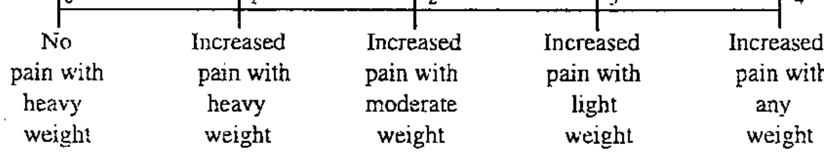
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



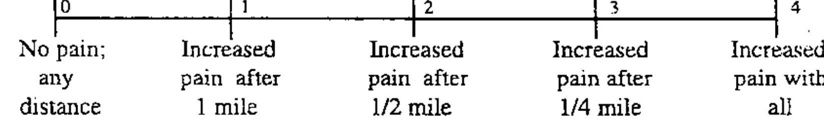
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



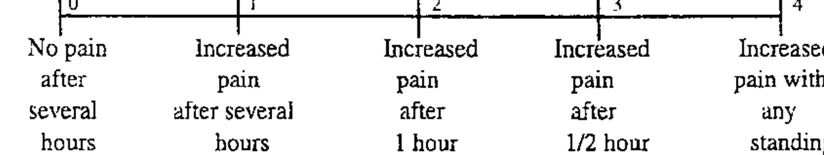
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

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

Name ______________________________
PRINTED

Total Score ________

____
Signature

____
Date

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www.chiroevidence.com

Kristen Steely, D.C.
Chiropractic Physician

Most of the patients that visit our office are on an affordable cash wellness plan. If you plan on using your health insurance, please provide the following information necessary for us to bill your insurance carrier.

Who is responsible for this account? ______________________________

Relationship to patient? ______________________________

Insurance Company ______________________________

Policy ID# ______________________________

Group # ______________________________

Subscriber's Name ______________________________

Birthday of Subscriber ______________________________

Social Security # of subscriber ______________________________

Social Security # of patient ______________________________

Subscriber's employer ______________________________

Assignment and release:

I certify that I and/or my dependent(s) have insurance coverage with ______________________________ and assign directly to Dr. Steely all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's signature ______________________________

Guarantor's signature ______________________________

(864) 226-7676 PHONE
(864) 226-7770 FAX
WWW.ANDERSONWELLNESS.NET

DR. KRISTEN STEELY
131 BUFORD AVE.
ANDERSON, SC 29621

Patient Policies

1. Patient must sign in at every visit.

2. Indicate on the SOAP note how you are feeling today and let us know of any new problems you have. *Don't forget name, date, and date of birth.* Do not leave anything blank.

3. Lie face down on the adjustment table. The reason we request that you do this is to relax; when you are relaxed, you receive a better adjustment.

4. REMINDER: If the doctor comes in to the adjustment room and the SOAP note is not filled out completely or you are not lying face down, the doctor will have you do this while moving on to the next patient.

5. To hold your preferred appointment time, we request all appointments be prescheduled.

6. All new injuries & concerns, re-exams, and consultations are to be discussed during extended hours not at your preferred appointment time.
   - Preferred hours *(adjustment only)*: 8:30-10:30; 3:30-5:30
   - Extended hours *(new problems, re-exams, consultations, new patients)*: 10:30-12; 2:30-3:30

7. Your results are obtained based on the number of visits per week, not per month. Therefore, it is vital to hold to your treatment plan schedule. If an emergency arises and you are unable to make your appointment, we ask you to notify us as soon as possible. An official make up appointment will be assigned for the following day at the same time. If you are prescheduled and miss three appointments in a row, you will be charged a missed appointment fee and all future appointments will be removed.

8. Payment is expected on the date of service unless you have an arranged payment plan with Healthcare Patient Solutions. If insurance does not pay after your visit has been filed, you have 30 days to pursue the claim *with your insurance company.* You will need to contact them.

Sign & Date ____

Authorization for Use and Disclosure of Health Information

While the law requires us to give you this disclosure, please understand that we respect the privacy of your health information. However, there are some circumstances in which we may disclose your health information.

- We may disclose your health information to another health care provider or a hospital if it is necessary to refer you for diagnosis, assessment, or treatment.
- We may disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclose, which you have the right to review before signing this form (§164.520). We reserve the right to change our privacy policy, but will notify you in writing of any changes either through the mail or when you come in for treatment. You may request a copy of our privacy policy at any time.

Your chiropractor and members of the practice staff may use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment, or other health related information. If contact is made by phone, a message may be left on your voice mail or answering device. By signing this form, you are giving us authorization to contact you in this manner.

Information that we disclose based on this authorization may be subject to re-disclosure by anyone who has access to the communication and may no longer be protected by the federal privacy rules.

You have the opportunity to designate a family member or other individual as a person with whom we may discuss your condition and treatment plan. **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?** ______________________________.

You may **restrict** the individuals or organizations to which your health care information may be released by notifying us in writing. We are not required to agree to your restrictions; however, if we do agree, the restriction is binding on us. You may **revoke** your authorization to us at any time, but your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. This decision will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I acknowledge that I have read and received a copy of this policy and authorization request and I hereby agree to the terms and authorize you to disclose my health information in the manner described above. This authorization is effective as of the date printed below and will expire seven years after the date on which you last receive services from us.

____

Patient Printed Name

____

Authorized Provider Representative

____

Patient Signature

____

Date

____

Date

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