Infinite HEALTH & WELLNESS GROUP

We Love Helping Children

Contact Information

Date: _____

First Name: _____
Middle Init: _____
Last Name: _____
Address: _____
City: _____
State, Zip: _____
Home Phone: (____)_____
Work Phone: (____)_____
Cell Phone: (____)_____
Email: _____

Sex: M F
Marital: Single / Minor

Birth Date: _____ Age: _____
Soc. Sec: _____
Who should we thank for referring you to our office?
_____

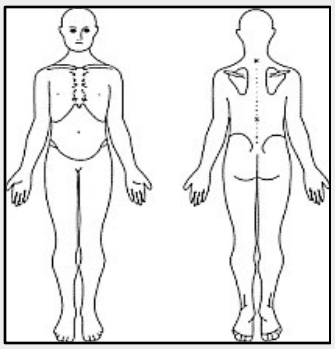
School Status: Full Time Part Time Other

This address will not be shared, sold, or distributed to anyone, but may be used to let you know about upcoming events or specials.

Method for Apt Reminders: Text Email Phone School: _____
PARENT's Names: _____
Pediatrician: _____ Race: Am. Indian Asian African Am Caucasian Other
Pediatrician Phone: _____ Ethnicity: Latin / Hispanic NON – Latin / Hispanic

PLEASE - LIST & DESCRIBE - EACH SYMPTOM YOU ARE LOOKING TO RESOLVE
IN ORDER OF SEVERITY (Mark X where you feel your Symptoms)

1._____
Date this complaint started? _____
At It's Worst: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (circle)
Right Now: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (circle)
Aching Stabbing Shooting Burning Stiff
Tingling Cramping Throbbing Tight Other
Is your condition getting worse? Yes No
Is your condition: Constant Comes and goes
Worse in: AM PM All Day At Night
This condition interferes with: Work Sleep Daily Routine



2._____
Date this complaint started? _____
At It's Worst: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (circle)
Right Now: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (circle)
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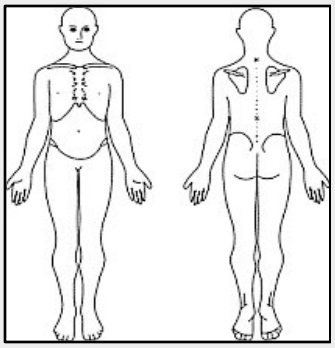

3._____
Date this complaint started? _____
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Tingling Cramping Throbbing Tight Other
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Worse in: AM PM All Day At Night
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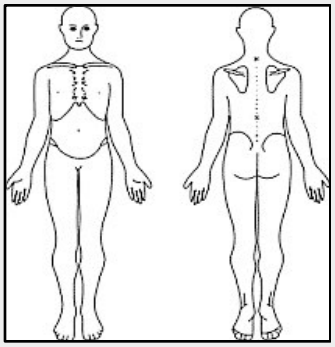

****What are ALL of your complaints above keeping you from doing / enjoying?** _____
****GOALS You are looking to achieve in our office:** _____

Patient Health History - Please Read and Check ALL That Apply

Past Treatments and Tests:
- ☐ MRI
- ☐ CT Scan
- ☐ X-rays
- ☐ Blood
- ☐ Orthopedist
- ☐ Physical Therapy
- ☐ Occupational therapy
- ☐ Neurologist
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage Therapy
- ☐ Surgery
- ☐ Plastic Surgery
- ☐ Speech Pathology
- ☐ Other _____
  _____

ALL Current Medications
(LIST BRAND AND MG/Day)

NAME MG/day
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ None

MEDICATION ALLERGIES
- ☐ _____
- ☐ _____
- ☐ NONE

- ☐ Height _____
- ☐ Weight _____

Past or Current Conditions:
- ☐ Allergies _____
- ☐ Fainting / epilepsy / seizure
- ☐ Headaches
- ☐ Migraines
- ☐ Sinus issues
- ☐ Ear infections
- ☐ TMJ
- ☐ Heart problems
- ☐ Dyslexia
- ☐ ADD - ADHD
- ☐ Asthma
- ☐ Colic
- ☐ Depression
- ☐ Psychiatric Disorders
- ☐ Diff Breathing _____
- ☐ Cancer: _____
- ☐ Digestive issues _____
- ☐ Hepatitis
- ☐ HIV /AIDS
- ☐ Menstrual Difficulties
- ☐ Hormone issues
- ☐ Growths / Tumors / Cysts
- ☐ Arthritis
- ☐ Herniated discs
- ☐ Neck pain
- ☐ Lower back pain
- ☐ Bladder issues
- ☐ Kidney issues
- ☐ Bowel issues
- ☐ Diabetes I II
- ☐ Scoliosis
- ☐ Walks Toes In / Toes Out
- ☐ Alcohol / Drug Abuse
- ☐ Artificial joints / Bones
- ☐ Vaccine injuries
- ☐ None of the above
- ☐ Other _____

Family History:
- ☐ None
- ☐ Heart Attack / Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Musculoskeletal
- ☐ Mental Disorders
- ☐ Neurological conditions
- ☐ Other: _____

Allergies (please list all)
- ☐ _____
- ☐ _____
- ☐ No Medication Allergy
- ☐ No Allergies

Vaccinations:
- ☐ Vaccinated?
- ☐ Unvaccinated?

Other Issues:
- ☐ Shoulder / Elbow Pain
- ☐ Wrist / Hand Pain / Injury
- ☐ Hip / Knee Pain / Injury
- ☐ Foot /Ankle Pains / Injury
- ☐ Rib Pains

(women) Are you pregnant?
- ☐ Yes _____ weeks
- ☐ No

SMOKING STATUS:
- ☐ Current everyday smoker
- ☐ Current sometimes smoker
- ☐ Former smoker
- ☐ Never smoker

Social History:
- ☐ Plays Video Games
- ☐ Play sports
- ☐ Studies long hours
- ☐ High stress
- ☐ Alcohol / Recreational Drugs
- ☐ Coffee _____ Cups / day
- ☐ Diet Soda / Drinks ____ / day
- ☐ Soda _____ / Day
- ☐ Processed Foods _____ /Day
- ☐ Fast food / Week _____
- ☐ Addictions: _____
- ☐ Vitamins _____
- ☐ Exercise _____
- ☐ Other: _____

Surgeries: (Please list ALL)
- ☐ None - Never

_____ Yr _____
_____ Yr _____

Major Accidents: (List all)
- ☐ None - Never

Recent Car _____ Yr _____
Car _____ Yr _____
Slip / Fall _____ Yr _____
Sports _____ Yr _____
Other _____ Yr _____

Fractured Bones: (List All)
- ☐ None - Never

_____ Yr _____
_____ Yr _____
_____ Yr _____

Please refrain from TALKING on your mobile device in the office. You may text / email or play games while waiting, but talking creates unnecessary stress to the other patients and staff. Thank you.

Financial - Insurance Information

Who is Responsible for this account? Self: Yes (No Parent/Guardian): Relationship: _____
Insurance Company: _____ Policy Number: _____
Subscriber's name: _____ Date of Birth: _____ SSN: _____

Assignment & Release of Benefits: I certify that I, and/or my dependents, have insurance coverage with the above-named insurance company, and assign directly to Dr. Bruce J. Cherlow 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 my signature on all insurance submissions. The above named Doctors may use my health care information and may disclose it to the above named insurance company, and their agents, to determine benefits or benefits payable for related services, and obtain payment for services rendered.

Signature: _____ **Date:** _____

Policies & Consent

Payment is due at the time of service, unless other arrangements have been made. I authorize and give consent to the Doctors & staff to perform any necessary services, during diagnosis and treatment. I have been given the opportunity to ask questions, and all risks have been explained. I understand the above written information on this form, and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____/_____/_____

Adult patient Parent or Guardian Spouse

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Informed Consent to Chiropractic Adjustments and Care at Infinite Health & Wellness Group

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.
I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, Physiotherapy, massage therapy, and other modalities including exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Physical/Physiotherapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Examinations have been/will be performed on me to minimize the risk of any complication from such treatments and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits, or how significant they will be. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing (staff or covering doctor).

Alternative Treatments Available
Reasonable alternatives to these procedures will be / have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. Rest/Exercise: It has been /will be explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery**. Non-treatment: I understand the potential risks of refusing or neglecting care, not following outlined recommendations, may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient _____
Signature of witness _____
Date and time _____

OFFICE USE ONLY: PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS
Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

[ ] Of legal age
[ ] Coherent and alert
[ ] Proficient in understanding the English language
[ ] Disoriented
[ ] On prescription/OTC medication but unimpaired

[ ] Assisted in understanding by an interpreter (Interpreter's name:_____)

[ ] Resolute in denying being under the influence of alcohol and or recreational drug use at the time of consent
[ ] Unable to give legal consent
[ ] Consent given thru legal guardian

I certify that the above accurately describes the above named patient's status during the informed consent process on :

_____ _____
Date Signature of Doctor

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	