Gillenwater Chiropractic, Acupuncture, and Nutrition Center

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

2110 EUCLID AVENUE
BRISTOL, VIRGINIA 24201
276-669-8683
gillenwaterchiropractic@yahoo.com
www.gillenwaterchiropractic.com
Established 1939

Terry H. Gillenwater, D.C., M.S., FIAMA
Masters of Science in Nutrition,
University of Bridgeport
Doctor of Chiropractic Palmer College
Fellow in the International Academy
of Medical Acupuncture
Diplomate National Board of Chiropractic Examiners

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ◯ No ◯ Yes **When?**

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | **Your Social Security Number** | **Birth Date (MM/DD/YYYY)** | **Age**

Your First Name | **Your Middle Name (or Initial)** | **Gender** ◯ Male ◯ Female | **Race**

Address | **Marital Status** ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated | **Ethnicity**

City | **State/Province** | **ZIP/Postal Code** | **Preferred Language**

Home Phone | **Cell Phone** | **Spouse's Name**

Email Address | **Child's Name and Age**

Emergency Contact | **Emergency Contact's Phone** | **Child's Name and Age**

Your Occupation | **Child's Name and Age**

Your Employer | **Work Phone**

Address | **May we contact you at work?** ◯ Yes ◯ No

City | **State/Province** | **ZIP/Postal Code** | **Preferred method of contact?** ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier | **Policy Number**

Insured's Last Name | **Birth Date (MM/DD/YYYY)** | **Who carries this policy?** ◯ Self ◯ Spouse ◯ Parent

Insured's First Name | **Insured's Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

1. The symptom(s) that have prompted me to seek care today include: ______________________

Patient name ______________________

Patient Number (office use only) ______________________

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other ______________________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ______________________

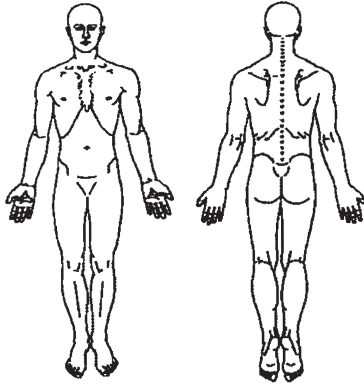
3. Onset (When did you first notice your current symptoms?) ______________________

4. Intensity (How extreme are your current symptoms?)
0◯-◯-◯-◯-◯-◯-◯-◯-◯-◯10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? ______________________

6. Quality of symptoms (What does it feel like?)
- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other ______________________

7. Location (Where does it hurt?) Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) ______________________

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ______________________
What tends to lessen the problem? ______________________

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ______________
◯ Physical therapy ◯ Massage ______________

11. What else should Dr. Terry Gillenwater know about your current condition? ______________________

12. How does your current condition interfere with your:

Work or career: ______________________

Recreational activities: ______________________

Household responsibilities: ______________________

Personal relationships: ______________________

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	NONE ◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ____

c. Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	NONE ◯ Initials ____

d. Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ____

e. Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ____

f. Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ____

g. Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ____

Consultation Notes

Doctor's Initials ______________________

(Continued from previous page)

h. Endocrine

Had	Have	Condition
○	○	Thyroid issues
○	○	Immune disorders
○	○	Hypoglycemia
○	○	Frequent infection
○	○	Swollen glands
○	○	Low energy

NONE ○ Initials ____

i. Genitourinary

Had	Have	Condition
○	○	Kidney stones
○	○	Infertility
○	○	Bedwetting
○	○	Prostate issues
○	○	Erectile dysfunction
○	○	PMS symptoms

NONE ○ Initials ____

j. Constitutional

Had	Have	Condition
○	○	Fainting
○	○	Low libido
○	○	Poor appetite
○	○	Fatigue
○	○	Sudden weight gain/loss (circle one)
○	○	Weakness

NONE ○ Initials ____

Patient name ____

Patient Number (office use only) ____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	Illness
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: ____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	Treatment
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____

○	○	Medications (prescription and over-the-counter):

____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

18. Family History

Some health issues are hereditary. Tell Dr. Terry Gillenwater about the health of your immediate family members current condition?

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

19. Are there any other hereditary health issues that you know about? ____

SOCIAL

20. Social History

Tell Dr. Terry Gillenwater about your health habits and stress levels.

Habit	Daily	Weekly	How much?
Alcohol use	○	○	____
Coffee use	○	○	____
Tobacco use	○	○	____
Exercising	○	○	____
Pain relievers	○	○	____
Soft drinks	○	○	____
Water intake	○	○	____

Hobbies: ____

Question	Yes	No
Prayer or meditation?	○	○
Job pressure/stress?	○	○
Financial peace?	○	○
Vaccinated?	○	○
Mercury fillings?	○	○
Recreational drugs?	○	○

Doctor's Initials ____

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

22. What is the major stressor in your life? ______________________

23. How much sleep do you average per night? _______ **Hours**

24. What is the type and approximate age of your mattress and pillow? ________

25. What is your preferred sleeping position? ____________

26. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ______________________

____

28. In addition to the main reason for your visit today, what additional health goals do you have? ______________________

____

Patient name

Patient Number
(office use only)

Consultation Notes

Acknowledgements
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 your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, 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 subluxation. 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 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 called to confirm or reschedule an appointment and 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 carrier 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 concern.**

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

Doctor's Initials

______________________________ Signature

______________________ Date (MM/DD/YYYY)

GILLENWATER CHIROPRACTIC, ACUPUNCTURE & NUTRITIONAL CENTER

2110 Euclid Ave.
Bristol, VA 24201
(276) 669-8683

Dr. T. H. Gillenwater

Here at the Gillenwater Chiropractic Center, we are happy to file your insurance for you. **Please note:** It is the patient's responsibility to monitor the processing and payment of claims. After payment is received and reviewed from your insurance carrier, any outstanding balances will be considered your responsibility. We will be glad to get a quote of benefits from your insurance carrier; however, a quote of benefits is NOT a guarantee of benefits. Your insurance carrier DOES NOT GUARANTEE PAYMENT until your claim is received and reviewed. If your insurance denies payment – REGARDLESS OF WHAT WAS QUOTED-it is your responsibility to pay.

Payments are expected at the end of each visit

This includes all co-pays, deductibles, co-insurance, etc. if we are filing insurance for you. If you are not filing insurance, then the total balance is due at the end of your visit unless prior arrangements have been made.

Worker's Compensation

There is a 90-day payment policy.
If no payment is received from your workers compensation insurance within the 90-day period from the date we filed, then you are responsible for the total balance due.

Personal Injuries

There is a 90-day payment policy.
We would be glad to file claims with the at-fault insurance carrier, but it can take months or even years to receive payment. Therefore, we need to also file with your health insurance. (Any payments made will be taken into consideration at the time of settlement with the at-fault carrier.)

Collection Policy

It is the policy of this office to allow patients' who are unable to pay in full on each visit to pay weekly or monthly payments as agreed upon. If you fail to make your monthly payments and do not contact us, you may be turned over to a collection agency after 90 days.

Signature________________________________ **Date**______________

Your health is always our primary concern.

Please sign below stating that you agree to the above conditions. If there is a financial problem, please feel free to speak to Betty or Carla about it and they will work with you.

Signature________________________________ **Date**______________

We would like to have your permission to contact you.

By signing below, you are agreeing that if we need to contact you, we have your permission to do so. You are also agreeing that we may leave a message on an answering machine/voice mail box, or with whomever answers the call.

Signature________________________________ **Date**______________

AUTHORIZATION AND ASSIGNMENT

TO: DR. T. H. GILLENWATER, D.C.
In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to the Insurance company, attorney, or general adjuster in order to process any claim for reimbursement of charges incurred me as a result of professional services by you, and I hereby release you of any consequence therein.

ASSIGNMENT OF CAUSE OF ACTION

In any event any insurance is obligated by contractual agreement to make payment to me or to you, I herby assign and transfer to you the cause of action that exists in my favor against such company (the name(s) if which is/are believed to be correctly set forth under pertinent data below) authorize you to prosecute said action either in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me; I understand I personally owe you, and agree to pay in a current manner.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

TO: DR. T. H. GILLENWATER, D.C.
In consideration of the chiropractic services rendered, I authorize and direct the payment to the doctor named above of any sum I owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services.

ACKNOWLEDGEMENT AND UNDERSTANDING

I herby acknowledge that I am receiving (or about to receive) health care services at the Gillenwater Chiropractic Office, and that I have been advised that the doctor providing the services is/are willing to wait for payment for these services, provided that there continues to be reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either: (**a**) that there is no insurance company obligated to pay for the services, or if the company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s) or (**b**) if a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s) or if I have not engaged the services of an attorney, then payment for these services rendered by the doctor(s) at Gillenwater Chiropractic Office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

INSURANCE DISCLOSURE

I, ______________________________, was informed in detail that my insurance may choose to make payment for some or all services provided by this office, and I hereby agree to be personally responsible for all services regardless of whether my insurance, be it Medicare or another, deem those services medically necessary or not. ***This applies to this service date as well as all dates to follow.**

I am choosing to allow my doctor, Dr. T. H. Gillenwater D.C., to provide any service he deems necessary for the correction of my current condition and any conditions in the future, regardless of Medicare's (or other insurance's) opinion.

I certify that I have read and fully understand the above information.

______________________________ ______________________

Patients Signature Date

______________________________ ______________________

Witness Date