



A Personal Message From Dr. Jonathan Woodward

Welcome !

Dr. Jonathan Woodward here. I wanted to take a few moments to personally welcome you to our practice and let you know a few very important things that will help you get the most out of your care.

First thing is – Our practice is referral driven. So we run a very “open” office. By this I mean we value your opinion and want to hear what you think. No matter what it is. If you like something – tell us so we can do more of it. And if you don’t like something – tell us that too. The only way we can make your experience with us the best it can possibly be is if we know what you want. If there is something you do not like – tell us RIGHT AWAY so we can rectify the situation. Do NOT be intimidated. We are only happy when YOU are happy.

Second: We want you to feel better and reach your goals as fast as humanly possible – for the least cost. We want to make sure you get out of pain and stay that way for the longest time possible. This means we will give you the best recommendation and treatment plan we feel will do that. Your treatment plan will be personalized for you. We do NOT hand out “canned” treatment plans to everyone.

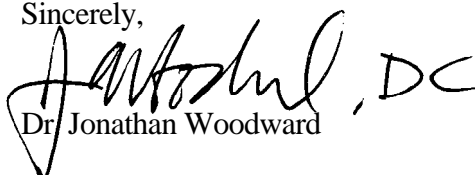
You are an individual and so is your treatment plan and the way we approach it.

If you have any questions about our recommendations or your personalized treatment plan – just ask. Like I’ve already said... we want to make this the best possible experience for you. We want you to get the most out of this – in the least time – for the absolute lowest cost. So please, if you have ANYTHING to comment on – we are all ears.

And third: I would like to say thank you for putting your confidence in me. I have worked very hard over the last 8 years to help as many patients as possible and build a great reputation. And I want to make sure I live up to my reputation for you. Because nothing matters unless YOU are happy.

So once again... WELCOME! I look forward to helping you achieve everything you came in for – as fast as humanly possible.

Sincerely,


Dr. Jonathan Woodward

WOODWARD CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION FORM

Date: _____

Gender: M or F

Name: _____ Email: _____

Date of Birth: ____/____/____ Age: _____ Social Security #: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Home Address: _____ City, Zip: _____

Employer: _____ Occupation: _____

Single Married Widowed Separated Divorced

Spouse/ Emergency Contact: _____ Daytime Phone: _____

(If Under 18) Name of Parent/ Guardian: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Patient Condition:

Describe the major complaints that brought you to our office: _____

Approx. when did your complaint begin? Gradually / Suddenly ____/____/____ Time _____ am pm

What caused it? _____

My pain is: Forgotten with Activity Noticeable but Able to Continue Activity Prevents Certain Activities

Activities that are difficult/ painful to perform: Sitting Standing Walking Lying Down
 Bending Turning Twisting

Does it affect your: Work Sleep Recreation Daily Routine

Has there been any change in the following since the onset of your complaint: No Change to Any of These

Balance Coordination Grip Weakness Breathing
 Hearing Vision Digestion Weight Menstrual
 Coughing Sneezing Urination Bowel Habits Sexual

Systems Review:

Are you currently having problems with any of the following? No Problems with Any of These

Skin/ Hair/ Nail Mouth/ Throat Nose/ Sinus Allergy/ Immunity
 Heart/ blood vessel Blood/ Lymph nodes Chest/ Lung Eye
 Arthritis/ Osteoporosis Glands/ Hormones Digestive Ear
 Prostate/ Testicular/ Vaginal Kidney/Bladder

Females only

Chance you are Currently Pregnant Breast problems Birth Control Pills (*check if taken ever*)

Past Medical History:

Has this condition occurred before? Yes No If yes describe: _____

Have you seen another doctor for this condition? Yes No Who? _____

Treatment Received Medication Surgery Physical Therapy Chiropractic Other: _____

Previous Chiropractor: Dr. _____ Phone: _____ Date of last visit? _____

Current Family Physician: Dr. _____ Phone: _____ Date of last visit? _____

May we communicate with your family doctor about your diagnosis/ treatment / progress in our office? Yes No

What **vitamins / over-the counter medications** are you taking? _____

What **prescription drugs** are you taking? _____

List any diseases you've had in the past **including childhood diseases**: _____

Tell us if you have been **diagnosed** as having a particular condition, such as diabetes, cancer, AIDS, etc: _____

List any **surgeries** you've had (ie. Appendix, tonsils, ear tubes, wisdom teeth, etc): _____

Hospitalizations other than those listed above? _____

List any physical **injuries** such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprain/strains, dislocations, and/or broken bones: _____

Family History:

List any diseases/ conditions that are common among your family members: _____

Lifestyle: How often do you?

Exercise: _____ per _____

Alcohol: _____ per _____

Tobacco: _____ per _____

Coffee/ Caffeine Drinks _____ per _____

Sit at a desk: _____ Hrs/day

Work on the phone: _____ Hrs/day

Work on a computer: _____ Hrs/day

How old is your bed's mattress? _____ Yrs

Consent:

I do hereby request and authorize Dr. Jonathan Woodward DC, associates, or assistants to perform examination and diagnostic procedures on me, or the person for which I am acting as guardian, for the condition(s) described above. I certify all the above questions have been answered truthfully to the best of my knowledge, and do not hold the doctor or clinic responsible for any harm caused due to my failure to disclose information requested on this form that would have otherwise altered their diagnosis and plan of care.

I understand that they have the right to refuse to accept me (or said minor) as a patient at any time before treatment begins. The taking of a history, the conducting of a physical examination, and the performance of any diagnostic procedures, are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Signature of Patient/ Parent / Guardian

Date

OFFICE USE ONLY

S: _____

O: _____

R: _____

Q: _____ I: _____ / _____

T: _____

Pa: _____ Pr: _____

S: _____

O: _____

R: _____

Q: _____ I: _____ / _____

T: _____

Pa: _____ Pr: _____

HIPAA & Our Privacy Pledge

At Woodward Chiropractic we are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition;
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services;
- We may need to 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 disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing and mailed to 5353 Alpha Rd Ste 110A, Dallas, TX 75240, Attn: Dr Jonathan Woodward. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. 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.

I have read your consent policy and agree to its terms. I also acknowledge that I have been offered a copy of this notice.

Printed Name of Patient / Personal Representative

Date

Signature of Patient / Personal Representative

Description of Representative's Authority