**Reservoir Chiropractic, Inc.**

**This is a summary of the following pages of our Privacy Notice. Please read this and following instructions. Feel free to take the Privacy Notice home with you.**

Here is how we protect your personal details:

1. We will make every effort to protect your personal information. In signing below, I acknowledge I have received a Privacy Notice from Reservoir Chiropractic, which is also displayed on bulletin board:

   _____ Date: _____

   Patient Signature

2. We will never profit by selling your name, or using it in any way inappropriately.

3. We would like to send you information occasionally in the mail or on email. This will be approximately one to two times a month,, and any other special notices re: office happenings. You may opt out of this now by stating it here. Otherwise, we will assume you authorize us to communicate with you.
   I wish to opt out of any mail contact, including email: Please sign here:

   _____

   ** I must inform you that if you sign here, you will receive nothing from our office in the mail. We cannot pick and choose which mail you get and which you don't, due to restrictions in our office software.

4. Signing this is voluntary, and if you do not, you will still receive the best health care possible by our staff. You may revoke the authorization at any time in writing to Dr. Joanie Winstead. You may request a copy of this signed form at any time.

I understand this form was completely filled in as I wanted it prior to signing. All my questions were answered to my satisfaction and I understand this form and all of its contents. I received a copy of the office's privacy notice.

*If coverage cannot be verified on the date of service payment in full may be required. **Also a $20.00 Non-Cancellation Fee will be charged if you miss an appointment or do not cancel 12 hours prior to appointment.** I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Reservoir Chiropractic is filing my insurance as a courtesy; and insurance is no guarantee of payment, as stated by the insurance companies when we check benefits. All charges due must be paid at the time of service unless payment arrangements are made. **I understand that my insurance company may not cover fully (or at all) my bills for services provided, and that I will be responsible for payment of all charges. In the event Reservoir Chiropractic refers my account to an attorney to collect an unpaid balance, I agree to pay reasonable attorney's fees incurred in the collection of the unpaid balance.** Reservoir Chiropractic will do our best to keep track, but is NOT responsible for counting the allowable NUMBER of VISITS or MAXIMUM DOLLAR benefits per calendar year. I understand this is shown on the EOB (Explanation of Benefits) that I receive from my insurance company after each visit.

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign

Name of Insurance Company

directly to Reservoir Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. 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(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize Dr. Joanie Winstead, and all associates, and assistants to render Chiropractic services as they deem necessary.

Patient Signature: _____ Date:___ /_____/_____

(or legal Guardian, parent, attorney)

Print Name:_____

Office Staff Witness: _____ Patient's Clinic I.D._____

# PATIENT INFORMATION

**Doctor: Joanie Winstead D.C**

Date _____ Patient ID:

| Patient's Name Last | First | Middle Initial | Social Security No. |
|---|---|---|---|
| | | | |

| Street Address | City and State | Zip Code |
|---|---|---|
| | | |
| **P.O. Box** | **City and State** | **Zip Code** |
| | | |

| Home Phone No. | Cell Phone No. | E-mail Address |
|---|---|---|
| ( ) | ( ) | |

| Date of Birth | Age | Sex | Marital Status S M D W | Who referred you? |
|---|---|---|---|---|
| | | | | |

| Patient's Employer | Occupation | Business Phone |
|---|---|---|
| | | ( ) |

| Employer's Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Spouse's Name | Spouse's Employer | Employer's Street Address | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Spouse's Occupation | Spouse's Date of Birth | Spouse's Cell Phone No. | Spouse's Social Security No. |
|---|---|---|---|
| | | ( ) | |

| In Case of Emergency Contact | Relationship | Contact's Home Phone | Contact's Cell Phone |
|---|---|---|---|
| | | ( ) | ( ) |

| Contact's Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Primary Care Provider | Referring Provider (if different from Primary Care Provider) |
|---|---|
| | |

## IF THE PATIENT IS A MINOR OR STUDENT

| Mother's Name | Street Address, City, State, and Zip Code | Home Phone No. |
|---|---|---|
| | | ( ) |

| Mother's Employer | Occupation | Cell Phone | Business Phone No. |
|---|---|---|---|
| | | | ( ) |

| Employer's Street Address, City, State and Zip | Social Security No. |
|---|---|
| | |

| Father's Name | Street Address, City, State, and Zip Code | Home Phone No. |
|---|---|---|
| | | ( ) |

| Father's Employer | Occupation | Cell Phone | Business Phone No. |
|---|---|---|---|
| | | | ( ) |

| Employer's Street Address, City, State and Zip | Social Security No. |
|---|---|
| | |

Is this a motor vehicle accident or work-related injury? **YES** **NO**

Is there a person or organization that you would like to share your health information with? **YES** **NO**

Patient Signature: _____

## Symptoms

Major Complaint:_____

Start date of symptoms?_____ Are symptoms/condition getting worse? Yes No

What activities aggravate it?_____What relieves it?_____

Rate the severity of pain (0-none to 10-severe): BODY AREA 1:_____ 0 1 2 3 4 5 6 7 8 9 10

BODY AREA 2:_____ 0 1 2 3 4 5 6 7 8 9 10

OTHER:_____ 0 1 2 3 4 5 6 7 8 9 10

Frequency of pain? constant/ frequent/ intermittent/ occasional/ infrequent/ none/ other_____

What activities are difficult? Sitting Standing Lying Down Bending Walking Other_____

Description of the pain: Sharp Dull Aching Burning Shooting Throbbing Numbness Tingling Stiffness Cramping Swelling Other_____

Have you ever had the same or similar condition/symptoms before? Yes No If yes, when?_____

Have you already received other treatment for your current condition?_____

Please list any other healthcare providers that you are currently under their care:

Provider Name_____Date of last visit_____/_____/_____

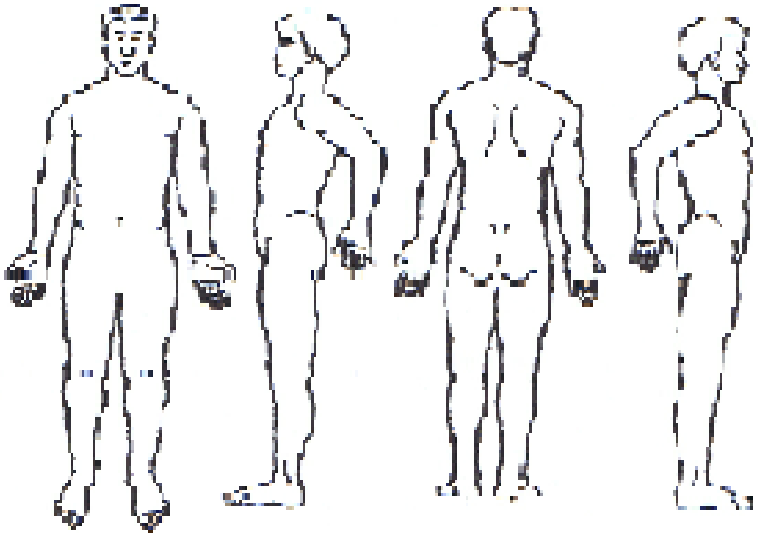
Provider Name_____Date of last visit_____/_____/_____

Provider Name_____Date of last visit_____/_____/_____

Have you seen a chiropractor in the past? Yes No If yes, who?_____

## Body Chart

Shade your symptom area. Place an "S" for sharp pain, a "T" for tingling, a "N" for numbness and a "D" for dull pain:



What desired activities are you unable to do because of your condition or pain?

_____

_____

_____

_____

_____

_____

_____

## Daily Habits

Do you exercise regularly? Yes No Describe?_____

Do you smoke or use tobacco products? Yes No How much per day?_____

How much alcohol do you consume on a weekly basis?_____

How much coffee, tea, or other caffeinated beverages do you consume per day?_____

Patient Name:_____Date:_____/_____/_____Patient I.D._____

## Health and Medical History-*Circle all the present conditions, and **underline** the past conditions. List approximate date condition began.*

| | | | | |
|---|---|---|---|---|
| Acid Reflux | Constipation | Headache | Migraines | Low Blood Pressure |
| AIDS/HIV | Depression | Heart Disease | Memory Loss | High Cholesterol |
| Allergies | Diabetes | Hepatitis | Miscarriage | Psychiatric care |
| Anemia | Diarrhea | Herniated Disc | Mononucleosis | Rheumatoid Arthritis |
| Anorexia | Difficulty Sleeping | Herpes | Multiple Sclerosis | Stroke |
| Appendicitis | Dizziness | High Blood Pressure | Muscle Weakness | Seizures |
| Asthma | Emphysema | Insomnia | Mumps | Shortness of Breath |
| Bloating | Epilepsy | Irritability | Osteoporosis | Nausea |
| Bronchitis | Fainting | Kidney Disease | Osteopenia | Vertigo |
| Bulimia | Fatigue | Liver Disease | Pacemaker | Nervousness/Anxiety |
| Cancer | Fever | Light Sensitivity | Indigestion | Suicide Attempt |
| Cataracts | Fractures | Loss of Smell | Pneumonia | Scoliosis |
| Chicken Pox | Glaucoma | Loss of Libido | Parkinson's | Thyroid Disorder |
| Cold Sweats | Goiter | Low Energy | Polio | Tonsillitis |
| Cold Feet or Hands | Gonorrhea | Measles | Prostate Disorder | Tuberculosis |
| TMJ Problems | Ulcers | Whooping Cough | Vaginal Infection | Prosthesis |

Other_____

***Women only***: Are you pregnant? No Yes
Number of weeks? _____
Nursing: No Yes

**List Family history of illnesses known:**
Mother:
Father:
Grandparents:
Siblings:
Aunts/Uncles:

**Have you had any of the following vaccines:**

| | | |
|---|---|---|
| Shingles | YES | NO |
| Pneumonia | YES | NO |
| Gardasil | YES | NO |
| Flu | YES | NO |
| Covid 19 | YES | NO |

List any surgeries or procedures which you have had:
_____Date_____/_____/_____
_____Date_____/_____/_____
_____Date_____/_____/_____

List any allergies you have:_____
List any medications or nutritional supplements you are currently taking:_____
_____
_____

Patient Name:_____Date:_____/_____/_____Patient I.D._____