New Patient Introduction

☐GI ☐WC ☐MC ☐PI ☐PP ☐CA ☐OTHER______________

Name:☐Mr. ☐Ms. ☐Dr.____Date:____-____-______.
(First) (Middle) (Last)

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Co-Habit Home Phone (___)_____-_______. Cel Phone (____)_____-_______.
Home Address____Work Phone (___)_____-_________.
(Street) (City, State) (Zip)

SS# _____________-______-_____________ Birth date_______-_____-______ Age__________
Email Address:____ ☐Male ☐Female

In case of emergency we should contact:
Name:___________________________ Relationship_____________________ Phone (_______)______-____________

Referred By: ____

Employed By: Name__________________________ Address____
Work Phone (___)______-_____________ (Street) (City, State) (Zip)

Name of person legally responsible.
(If patient is a minor, name of parent, guardian, etc.)____________________________________

Health Insurance ☐**PPO** ☐**HMO** ☐**NONE**
Do you have Medicare ☐Yes ☐No #__________________
1st Insurance Company_________________________________ 2nd Insurance Company________________________________
3rd Insurance Company_________________________________
Are you the insured? ☐Yes ☐No Are you the dependant? ☐Yes ☐No

What is the reason for today's visit: ☐ **I am in Pain** ☐ **Improve overall Health**
What activities are affected by your current condition in your personal life?____
____
How does your current condition affect your ability to perform your work? ____
____
Do you want to improve or gain relief from your current condition? ☐Yes ☐No

You are currently a candidate to receive care in this office!
If you are accepted as a patient in this office how committed are you to obtaining relief from your current condition? (Circle One)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Complete this section if you have been in a Motor Vehicle Accident;
Date of injury:____-_____-______ Estimated Cost of vehicle damage $______________________________
Were you at fault? ☐**Yes** ☐**No** If No, Name of at fault Insurance Company ______________________________
Phone Number of at fault Insurance Company (__)_______-_____________
Has the at fault Insurance Company accepted liability? ☐**Yes** ☐**No** ☐**Not Sure**
Do you have an Attorney? ☐**Yes** ☐**No** If No would you like to consult an Attorney for legal advice? ☐**Yes** ☐**No**
Name of your Auto Insurance Carrier at the time of the Accident____
Phone (___)__________-_____________ Auto Ins. Policy #____

In order to control your cost of billings, we request that our charges for office visits be paid at the conclusion of each visit. (Unless a financial plan/arrangement has been agreed upon with our financial department.)

If this account is assigned for collections and/or suit, collection cost and/or interest, and/or attorney's fees, and/or court costs will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
I, ________________________(Print Name) hereby assign all medical and/or health care benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: **The Agape Wellness Center Inc.** and/or Dr. Jennifer K. Paalani and affiliate companies/corporations. This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Signature X_____________________________ **Date:**_______________

Responsible Party Signature X________________________________ **Date:**_______________

Consent for Chiropractic Care & X-Ray (Radiology)

When a person seeks Chiropractic Care and a Doctor accepts a patient for such care, it is very important that this patient have an understanding on the goal of the Chiropractic care and the means in which we will attain it.

First, the process of Chiropractic is not a substitute for medical treatment. Patients usually want relief from whatever symptoms, ailments or conditions are bothering them. This however, is NOT the goal of the Chiropractor.

The purpose of the Chiropractor is to restore and to maintain the integrity of the spinal cord and the nerve roots that are protected by the bones in the spine (vertebras). Tiny misalignments of these vertebras or bones in the spine that interferes with the nerve pathways are call **subluxation (sub-lux-A-shun).**
By means of Chiropractic adjustment subluxations are corrected. Thus normal nerve functions are restored to their normal state. When the nerve function is restored the body is able to function at a more optimal health level. By maximizing your health potential you maximize your life potential.

I, ____________________ Have read the above and, understand it fully and am willing to undertake and/or consent for Chiropractic care on this basis.

If applicable;
Name of Child consenting for:_______________________________
Consent for this child's X-rays

Patient Signature X___________________________ Date:___________

Female Patients ONLY:
ALL FEMALE PATIENTS are asked to please answer the following questions concerning possible pregnancy. This information is only for the PRIVACY ACT governs providing radiation protection and its release.

1. Have you had an operation which has made you steril? YES NO
   If YES what type:______________________________

2. Do you use birth control? YES NO
   If YES what type:______________________________

3. Is there ANY possibility that you could be pregnant at this time? YES NO

I, ____________________ confirm that according to the best of my knowledge, I am not pregnant. My last menstrual period was on:____________

Patient Signature X___________________________ Date:___________

Privacy Act Statement: *Authority Section, 108, 1071-87, 3012, 5031 and 8012 Title 10, United States Code and Executive Org. 9397*
Purpose: To document possible pregnancy in all women of childbearing age.
Routine Uses: To prevent X-Ray exposure to potentially pregnant females.
Disclosure is Mandatory: Failure to disclose the required information will result in possible delay or cancellation of X-Ray examination.

MISSED APPOINTMENT POLICY

In an effort to continue to provide the quality service the patients of the Agape Wellness Center have grown accustom to, we request our patients to schedule their appointment times with the front desk so that the doctors and staff may better serve your needs. Additionally we understand that ALL of our schedules sometimes can be unpredictable and the need to change an appointment might be necessary. If a change is necessary Please allow our staff **24 hour advance notice** so they can replace your appointment with another patient from our waiting list.

I have read and understand the above MISSED APPOINTMENT POLICY. I Acknowledge and agree to personally pay **$40** for any missed appointment that I am unable to give a 24 hr advance notice of cancellation.

Patient Signature X______________________ **Date:_________**

Medical Records Release

This is to verify that I, _________________(Print Name) have requested the release of ANY and ALL medical records/File (including but not limited to X-Ray, progress notes, diagnosis, testing and reports) which are part of the office records of:

Provider Name:_____________________________
Provider Clinic:___________________________________
Provider Address:_________________________________
Provider Phone Number:___________________________
Provider Fax Number:______________________________

I hereby acknowledge receipt of these medical records, and agree to the following points:

1. I hereby release and discharge the above Provider from any and all responsibility and/or liability related to medical records.
2. I understand that these records are the property of Provider, and I agree to handle these medical records with any and all HIPPA patient privacy policies that apply.
3. I agree to take good care of these records, being careful not to distort, tear, damage or alter them in any way.
4. This transaction is done at my specific request.
5. I Authorize these medical records to be released to:

Agape Wellness Center
Medical Records Mailing Address:
PO BOX 10672
Costa Mesa CA 92627
Phone (714) 957-6889
Fax (714) 546-8616

[***PLEASE PRINT***]
PATIENT NAME ____
ADDRESS____
CITY_____________________ STATE__________ ZIP________

Patient Signature X____________________________ **Date:____________**

HIPAA RELEASE, and RELEASE OF INFORMATION (1)

To: **Agape Wellness Center**

In consideration of your undertaking to treat me, I, ___________________ (Patient Name), accept and agree to all of the following terms:

Release of Information

I, ____________________ (Patient Name), being of full age, do hereby consent pursuant to the security requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) to allow Agape Wellness Center to transmit my records by fax, e-mail, or any other electronic means at his/her sole discretion and as s/he sees fit, to obtain payment or reimbursement from my insurance carrier, from me, or to communicate with my attorney, insurance carrier, or other party as required for the administration of my affairs. Furthermore, I give Agape Wellness Center permission to post my name in his/her office as a source of referrals. I also authorize Agape Wellness Center to release any information necessary about my account to State or Federal authorities, or to attorneys or professional societies or associations, or to anyone else requiring it, for the purpose of [a] documenting discrimination or persecution of Agape Wellness Center or of this doctor's profession or [b] to obtain increased benefits for my case or for this doctor's profession, including class actions.

To my insurance carrier: You may release any information regarding my records to Agape Wellness Center, and I herewith demand a copy of any independent examination reports automatically be forwarded to him/her, for which I accept responsibility for any reasonable charge applicable thereto, pursuant to law.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of reimbursement of the Doctor for the services provided shall be the interpretation which shall prevail.

If you understand and accept the foregoing, please sign on the line provided below:

Signed : **X** ____ Date:_________________

(Patient Name)

AUTHORITY TO PAY DOCTOR OR CHANGE OF ADDRESS FOR MAILING PURPOSES (2)

To: Agape Wellness Center
Address: 1182 Bristol Costa Mesa CA 92626
Tax ID:

In consideration of your undertaking to treat me, I, ___________________ (Patient Name), accept and agree to all of the following terms:

Authority to Pay Doctor

I authorize the direct payment to you, Agape Wellness Center, and hereby DIRECT that each and every payment for the services provided to me in the office of Agape Wellness Center be paid to the order of Agape Wellness Center, at 1182 Bristol Costa Mesa CA 92626, and holding the Tax Identification number listed above i.e., the full amount of any sum that I now or hereafter may owe Agape Wellness Center, I specifically authorize either my insurance carrier or my attorney to make such payments out of the proceeds of any settlement of my case, or for which my insurance carrier may have been billed, or for which I may otherwise be obligated to make payment to Agape Wellness Center, based in whole or in part on the charges made for services provided in the office of Agape Wellness Center. Or, in the alternative, if for any reason, my insurance carrier may not by nature of its contract terms pay to the order of the Doctor, then, and ONLY then should it pay to my order, but I then DIRECT, pursuant to my rights under applicable Federal Statute, that the insurance carrier or attorney should mail such payment directly to me c/o Agape Wellness Center at 1182 Bristol Costa Mesa CA 92626.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of payment of Agape Wellness Center for the services provided shall be the interpretation which shall prevail.

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed : X____ Date:____________
(Patient Name)

Witness: _________________________________

Attorney of Record (If Represented)

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such for any settlement, judgment or verdict, as may be necessary to adequately protect Agape Wellness Center

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed : X______________________________ _______________ Date:_________________
(Print Name)

____

____

AUTHORITY TO SIGN INSURANCE CHECKS RECEIVED AND FILE COMPLAINTS (3)
To: Agape Wellness Center

In consideration of your undertaking to treat me, I, ___________________ (Patient Name), accept and agree to all of the following terms:

In the event that any check made payable to me for services rendered to me by Agape Wellness Center, is received by Agape Wellness Center, or any form required to be completed for payment or reimbursement by any carrier is not filed by me personally, I hereby give full and complete authority, by way of limited power of attorney for this purpose to Agape Wellness Center to sign my name, or a facsimile thereof, to such check or form for the purpose to deposit it into his account as payment of my debt to him, or, with respect to forms, to file them for benefits with my carrier or that of any third party from whom I am otherwise entitled to benefits under the insurance laws of California. This authority shall be irrevocable during such period as there exists a balance on my account in the records of Agape Wellness Center. Agape Wellness Center accepts responsibility to credit my account for the payment in the amount of the face value of such an instrument, and keep either a paper or electronic record of the instrument in my records, which I may see on reasonable notice to Agape Wellness Center. Agape Wellness Center may also sign my name, or a facsimile thereof, to any complaint form required by him to file a complaint with the State Authorities against my insurance carrier, attorney ethics committee or other agency necessitated by circumstances resulting from efforts to collect any outstanding claims on my account.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of payment or reimbursement to Agape Wellness Center for the services provided shall be the interpretation which shall prevail.

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed : X____ Date:__________________

(Patient Name)

Witness: _________________________________

ASSIGNMENT SHALL BE IRREVOCABLE (4)

ACKNOWLEDGEMENT OF DUTY TO TURN OVER FUNDS

To: Agape Wellness Center

In consideration of your undertaking to treat me, I, ___________________ (Patient Name), accept and agree to all of the following terms:

In the event that any insurance carrier, attorney or other party, obligated by contractual agreement to make payment either to me or to Agape Wellness Center for the charges made for services provided, refuses to make such payment upon demand by Agape Wellness Center, I hereby assign and transfer any and all cause(s) of action which may exist in my favor, against any such insurance carrier, attorney or other party, and authorize Agape Wellness Center (such authorization shall be irrevocable), to prosecute said action, either in the name of Agape Wellness Center or in my name (and in my place and stead) whichever shall be the most beneficial to Agape Wellness Center, and at the sole discretion of Agape Wellness Center, as Agape Wellness Center sees fit. Further, I authorize Agape Wellness Center to compromise, settle or otherwise resolve such claim as Agape Wellness Center sees fit. I also authorize Agape Wellness Center to represent him/her self as me in any dealings with my insurance carrier, attorney or other party, in this matter, as necessary to obtain any information required to prosecute this assignment, or settle, compromise or resolve any legal matter which shall be brought or which shall otherwise assist Agape Wellness Center in getting paid in full for any and all claims related to the care or treatment that I received from Agape Wellness Center. This shall extend even to the point of Agape Wellness Center having authority to discharge any attorney to settle any matter ProSe, or by appointment of Counsel of choice by Agape Wellness Center, on my behalf if required to obtain payment of my account, should my attorney's actions necessitate doing so. This decision shall be in the sole discretion of Agape Wellness Center. I further agree that the foregoing shall be binding until Agape Wellness Center is paid in full, and will be irrevocable for the period until the balance on my account is reduced to zero. I understand that any payment which may be received by me, whether accidentally or deliberately from my insurance carrier, attorney or other party, while I owe a balance to Agape Wellness Center, is to be construed as the doctor's property, and I may be prosecuted civilly and criminally (under the appropriate State law) if I fail to immediately turn these funds over to Agape Wellness Center and/or if I divert these funds in any way, regardless of any advice I may have had from my attorney to the contrary. I agree that any such diversion shall constitute conspiracy to commit theft of services, and I understand that I may be prosecuted therefore.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of payment or reimbursement of Agape Wellness Center for the services provided shall be the interpretation which shall prevail.

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed : X____ Date:____________________

(Patient Name)

Witness: _________________________________

BALANCES DUE FROM PATIENT
(ARBITRATION WAIVER)
(5)

To: Agape Wellness Center
In consideration of your undertaking to treat me, I, ___________________ (Patient Name), accept and agree to all of the following terms:

Patient Responsible for Balance

I understand that I am fully responsible for and personally liable for any and all amounts charged by Agape Wellness Center for the services Agape Wellness Center may render to me after reasonable efforts have been made to collect the fees for those services from my insurance carrier, and whether any efforts have been made or not, and regardless of whether any such sums are paid by the insurance carrier, I understand that all submissions to my carrier or any carrier so obligated to make payment or reimbursement under any provision of the insurance law, or otherwise, is for payment or reimbursement to me for my debt to Agape Wellness Center, and that Agape Wellness Center is not a party to my contract with my insurance company.

Doctor's WAIVER of balance in event of Arbitration

If, in the sole discretion of Agape Wellness Center, should s/he choose to file an action pursuant to Law under provisions allowing said claim to be adjudicated by the American Arbitration Association or equivalent organization, and ONLY in this event, then Agape Wellness Center hereby specifically waives all additional rights to pursue any other party, to the extent prescribed by Statute for any balance due, and accepts the adjudication of the American Arbitration Association or equivalent organization as binding.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of payment or reimbursement of Agape Wellness Center for the services provided shall be the interpretation which shall prevail.

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed : X____ Date:__________________

(Patient Name)

Witness: _________________________________

ACCEPTANCE OF FEE SCHEDULE

ACKNOWLEDGEMENT OF RECEIPT THEREOF (6)

To: Agape Wellness Center

In consideration of your undertaking to treat me, I, ____________________(Patient Name), accept and agree to all of the following terms:

Acceptance of Fee Schedule

I have been made aware of the availability of Agape Wellness Center's fee schedule for me to review at any time, and I believe it to be reasonable, customary and usual in nature, and will herein agree to be responsible for any differential between what any insurance carrier, attorney, or other party deems reasonable and the actual fees charged by the doctor.

Survivability Clause / Interpretation

In the event that any provision of the foregoing document is found void or violates any provision of any State or Federal Statute, then all other provisions of this Agreement shall remain in full force and effect. Moreover, it shall be expressly understood that in the event that there is found to be more than one interpretation of the foregoing document, then that interpretation which most nearly serves to fulfill the purpose of payment to or reimbursement of Agape Wellness Center for the services provided shall be the interpretation which shall prevail.

If you understand and accept all of the foregoing, please sign on the line provided below:

Signed :X ____ Date:__________________

(Patient Name)

Witness: __________________________________

SYMPTOMS SURVEY Indicate ALL that apply

HEAD
- ☐ Headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels Heavy
- ☐ Light Headed
- ☐ Fainting
- ☐ Light Bothers eyes
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

NECK
- ☐ Pain in Neck
- ☐ Neck Pain with Movment
- ☐ Stiff Neck
- ☐ Muscle Spasms in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

HIPS, LEGS, FEET
- ☐ Pain in the buttocks
- ☐ Pain in the hip joint
- ☐ Pain down the leg (R-L)
- ☐ Pain down both legs
- ☐ Leg Cramps
- ☐ Pins & Needles in leg (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbenss of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Pain in foot (R-L)
- ☐ Pain in knee (R-L)

LOW BACK
- ☐ Low Back Pain
- ☐ Low Back Pain Worse When:
  - ☐ Working
  - ☐ Lifting
  - ☐ Stooping
  - ☐ Standing
  - ☐ Sitting
  - ☐ Bending
  - ☐ Coughing
- ☐ Muscle Spasm

MID BACK
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabing pain in mid back
- ☐ Muscle spasms

ABDOMEN
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

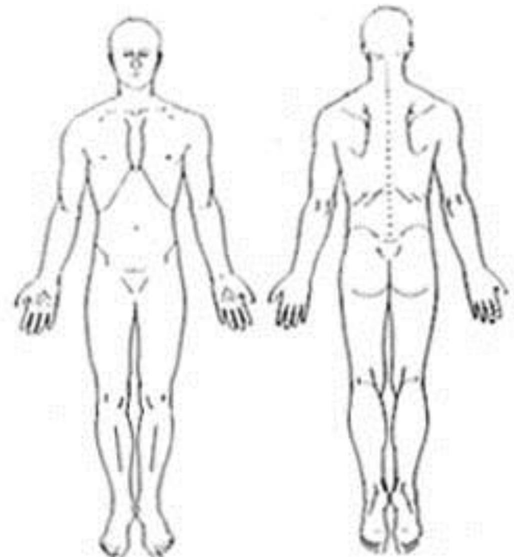
GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ General feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight

SHOULDERS
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arms above shoulder (R-L)
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched Nerve in shoulders (R-L)

ARMS & HANDS
- ☐ Pain in upper arm (R-L)
- ☐ Pain in forearm (R-L)
- ☐ Pain in hand (R-L)
- ☐ Pain in finger (R-L)
- ☐ Sensation of Pins & Needles in arm (R-L)
- ☐ Sensation of Pins & Needles in fingers (R-L)
- ☐ Fingers go to sleep (R-L)
- ☐ Hands cold (R-L)
- ☐ Swollen Joints in fingers (R-L)
- ☐ Sore joints in fingers (R-L)
- ☐ Arthritis in fingers(R-L)
- ☐ Loss of grip strength (R-L)

CHEST
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Pain around the ribs

Please indicate the area of MOST Discomfort:



Additional information:________________________________

____

____

____

____

____

____

Past Medical History

Activities of Daily Living (General)

Indicate any of the following that are affected by your current condition:

___Walking ___Sitting ___Climbing Stairs ___Chewing ___Getting in/out of auto
___Kneeling ___Sleeping ___Standing ___Lifting Children ___Reading ___Swimming
___Playing Piano ___Sexual Intercourse ___Using Telephone ___Running ___Bending
___Lying in bed ___Using Typewriter/Computer ___Exercising ___Sitting in recliner
___Other_______________________

Prior Symptoms

Date	Description	Frequency	Severity
__/__/____	______________________	___Once ___Several Times ___Periodically	Mild, Mod, Serve, Varies
__/__/____	______________________	___Once ___Several Times ___Periodically	Mild, Mod, Serve, Varies
__/__/____	______________________	___Once ___Several Times ___Periodically	Mild, Mod, Serve, Varies

Previous **Accidents**

Date **Description**
__/__/____ ______________________
__/__/____ ______________________

Previous **Illnesses**

Date **Description**
__/__/____ ______________________
__/__/____ ______________________

Current **Medications** ______________ ______________ ______________
______________ ______________ ______________

Previous **Surgeries**

Date **Description**
__/__/____ ______________________
__/__/____ ______________________

Family History

Marital Status: ___Single ___Married ___Divorced ___Widow ___Widower
Spouse Occupation______________________ Children? Yes No #Girls_____ #Boys_____
Biological Mother alive? Yes No Biological Father alive? Yes No
Have any family members died from any cause **other than old age**?

Relationship to patient,	Age;	Cause of Death
____________	_____	______________________
____________	_____	______________________
____________	_____	______________________
____________	_____	______________________

Are there any other family members that suffer from the **same or similar health problems** that are affecting you? Yes No

Name	Age	Relationship
____________	_____	______________________
____________	_____	______________________
____________	_____	______________________

Does any member of the family have any of the following illnesses: ___Diabetes ___Asthma ___Cancer ___Heart disease
Are there any other family members that have **mental impairments**? Yes No

Name	Age	Relationship of family member with mental impairment
____________	_____	______________________
____________	_____	______________________

Past Medical History

PLEASE FILL OUT THE FOLLOWING SHEET IF YOUR CURRENT CONDITION IS THE RESULT OF A MOTOR VEHICLE ACCIDENT.

AUTO ACCIDENT Date of accident:____________________ Time of accident:___________

Patient Vehicle

Where were you in the vehicle? _ __Driver's front seat……___Driver's rear seat………__Passengers side front seat
___Right rear seat

Your speed?_________MPH

Vehicle Type? ___Compact car…………___Full size car……___Mid size car……___Mini Van……___ Motorcycle
___Passenger Truck…..….___Passenger Van

What was you vehicle doing immediately prior to impact?___Changing lanes ___Slowing Down ___Stopped at a stop sign…….___Stopped at a traffic light….. ___Turning left at an intersection………. ___Turning right at an intersection

What was you vehicle's point of impact? ___Front Bumper………___Rear Bumper……… ___Left Side…..___Right Side

What was the amount of damage to your vehicle? $____________ …. ___Total Loss-suspect? YES……..NO

Road condition? ___Covered with gravel………___Damp…………___Dry……___muddy…………___Sandy………___Wet

Visibility?...........___Excellent with bright sunlight………..___Excellent with overcast light…………___Reduced at dawn…………
___Reduced at dusk
___Reduced at night…………………….. ___Reduced due to for………………….. ___Reduced due to rain……..
___Reduced due to snow

Was there another vehicle involved?……YES……..NO Number of vehicles?___

Which vehicle hit the other? ___More than one vehicle hit the patient's vehicle…..__ _The other vehicle hit the patient's vehicle
___The patient's vehicle hit the other vehicle………___The patients vehicle was hit by more than one
___The patient's vehicle was rear-ended by one…..___The patient's vehicle was rear-ended by one with multiple impacts

Was there a police report filed?…………YES……..NO

Patient at impact

Did air bags deploy…..YES NO Patient lose consciousness after injury…..YES NO

Patient received emergency care at scene..…YES NO

Type(s) of seat restraints, patient was wearing: ___Shoulder harness connected to the door…___Shoulder harness only……
___Lap belts only…..___NO Seatbelt…………___Seatbelt with shoulder harness

Patient was prepared for impact…………YES……..NO

Where did the patient go immediately after accident?___Continued to work ___Home ___Industrial Clinic
___to a walk in emergency ___to continued with scheduled plans ___to the hospital emergency room ___To work
___took children to pediatrician

Any additional details:____
____

Other vehicle

Other vehicle type: ___Compact car ___Full size car ___Mid size car ___Mini van
___Motorcycle ___Passenger Truck ___Passenger Van

What was the other vehicle doing immediately prior to impact? ___Changing lanes……… ___Slowing Down
___Stopped at a stop sign…….. ___Stopped at a traffic light…… ___Turning left at an intersection……….
___Turning right at an intersection

What was the other vehicle's point of impact? ___Front Bumper ___Rear Bumper ___Left Side ___Right Side

What was the amount of damage to the other vehicle? $____________ …. ___Total Loss-suspect? YES……..NO

AGAPE WELLNESS CENTER EXAM FORM

Doctors Section to be completed by the doctor

NAME________________ DATE OF BIRTH____________ SEX____________ Date____________

Objective Findings

Spinal Examination~ Motion & Static Palpation Revealed the following:

Restricted ROM	Pain, Edema, Temp Differential & Tonicity			Vertebral Tenderness & Fixations
Cervical Spine…………….	Mild…………………	Moderate…………..	Severe…………….	Occ, C1, C2, C3, C4, C5, C6, C7
Thoracic Spine…………….	Mild…………………	Moderate…………..	Severe…………….	T1, T2, T3, T4, T5, T6, T7, T8, T9
Lumbar Spine………………	Mild…………………	Moderate…………..	Severe…………….	T10, T11, T12, L1, L2, L3, L4, L5
Pelvic Region………………	Mild…………………	Moderate…………..	Severe…………….	LSAC, RSAC, LIL, RIL

Sensory Exam~

Exam Type…………………___**Manual Stimulation**
Exam Performed…………..___Pinwheel…………………..___Tuning Fork
Region Examined………… ___ Arm…………… ___Fingers…………___Foot
___Forearm………. ___Hand……………___Shin…………….___Thigh

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Dermatomes…… Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5
LSAC, RSAC, LIL, RIL

Pain……………..Yes…….. No Paresthesia…….Yes……...No………

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Exam Type…………………___**Tendon Reflex**
Exam Performed…………..___Achilles………. ___Biceps
___Brachioradialis…___Patellar………. ___Triceps

Left Finding	+4,	+3,	+2,	+1,	0 Absent
Bilateral Finding	+4,	+3,	+2,	+1,	0 Absent
Right Finding	+4,	+3,	+2,	+1,	0 Absent

Additional Notes:____________________

Muscle Exam~

Exam Type…………………___**Muscle Test**	Location	Grade	Additional Notes
Muscle Selection Region….___Foot/Soleus………………..	L Bi R……………	1 2 3 4 5……….	________
Muscle Selection Region….___Hip/Psoas…………………..	L Bi R……………	1 2 3 4 5……….	________
Muscle Selection Region….___Legs/Quads………………..	L Bi R……………	1 2 3 4 5……….	________
Muscle Selection Region….___Shin/Calf-Tib. Anterior……	L Bi R……………	1 2 3 4 5……….	________
Muscle Selection Region….___Shoulder/Deltoid Medial …	L Bi R……………	1 2 3 4 5……….	________

Assessment/Dx

1.________ 2.________ 3.________ 4.________

Current Status
___Chronic ___Chronic Permanent
___Reoccurrence Mild, Moderate, Severe
___Plateau
___Acute
___Acute Mild Exacerbation of Chronic Condition
___Acute Moderate Exacerbation of Chronic Condition
___Severe Exacerbation of Chronic Condition
___Sub Acute

Type Written Assessment:____________________

Plan

Modality/Procedure	Region					
___Adjustment……………………………	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Therapeutic Exercise………………..	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Manuel Therapy…………….. ………	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Acts Daily Living……………………..	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Neuro Muss. Re-education…………	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___ICE………………………………….	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Manuel Traction………………………	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Paraffin Bath…………………………	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Interferential…………………………..	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Ultrasound…………………………….	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___E-Stem………………………………..	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Other________	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Other________	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________
___Other________	Cervical	Thoracic	Lumbar	Extremity ________	Other________	, ________

General Physical Examination

Orthopedic and Neurological Examinations

Orthopedic Exam	Left	Right	Bilateral
______________________________	+…..-…	+…..-…	+…..-…
Present/Absent			
______________________________	+…..-…	+…..-…	+…..-…
______________________________	+…..-…	+…..-…	+…..-…
______________________________	+…..-…	+…..-…	+…..-…
______________________________	+…..-…	+…..-…	+…..-…
______________________________	+…..-…	+…..-…	+…..-…
______________________________	+…..-…	+…..-…	+…..-…

Neurological Exam	Left	Right	Bilateral
	Present/Absent	Present/Absent	
______________________	P……….. A…..	P……….. A……	P……….. A
______________________	P……….. A…..	P……….. A……	P……….. A
______________________	P……….. A…..	P……….. A……	P……….. A
______________________	P……….. A…..	P……….. A……	P……….. A
______________________	P……….. A…..	P……….. A……	P……….. A
______________________	P……….. A…..	P……….. A……	P……….. A

Range of Motion Examination

Cervical ROM:	Normal	Today	Pain Level
Flexion……………..	50………	_____…..	1……….. 2…………3
Extension…………..	60………	_____…..	1…………2…………3
Rt Lat Flexion……...	45………	_____…..	1…………2…………3
Lt Lat Flexion………	45………	_____…..	1…………2…………3
Rt Rotation…………	80………	_____…..	1…………2…………3
Left Rotation………	80………	_____…..	1…………2…………3
Other: __________________			
Flexion…………………………		_____…..	1…………2…………3
Extension ……………………..		_____…..	1…………2…………3
Rotation………………………		_____…..	1…………2…………3
Adduction…………………….		_____…..	1…………2…………3
Abduction……………………..		_____…..	1…………2…………3
Varus Angle…………………..		_____…..	1…………2…………3
Valgus Angle…………………		_____…..	1…………2…………3

Lumbar ROM:	Normal	Today	Pain Level
Flexion	90………	_____…..	1……….. 2…………3
Extension	25………	_____…..	1…………2…………3
Rt Lat Flexion	25………	_____…..	1…………2…………3
Lt Lat Flexion	25………	_____…..	1…………2…………3
Other: __________________			
Flexion…………………………		_____…..	1…………2…………3
Extension ……………………..		_____…..	1…………2…………3
Rotation………………………		_____…..	1…………2…………3
Adduction…………………….		_____…..	1…………2…………3
Abduction……………………..		_____…..	1…………2…………3
Varus Angle…………………..		_____…..	1…………2…………3
Valgus Angle…………………		_____…..	1…………2…………3

Physical Exam

Vital Signs

Hand dominance R L Height____ ft ____in Weight__________ Temp__________ Pulse__________ Respirations__________

Blood Pressure	Left	Right	
Systolic……………	_____	_____	……………… Sitting,……………...Standing,………….. Supine
Diastolic……………	_____	_____	

Postural/Mental/Physical

Walk/Gait

___Limp Favors Left Leg ___Limp Favors Right Leg ___Ataxic………… ___Circumductive ___Normal………… ___Scissor
___Decrease Arm Swing on the right side base of support

Movement: (check ALL that apply)

___Guarded ___Restricted Cervical and Lumbar ___Restricted cervical movement ___Restricted lumbar movement
___Restricted thoracic movement ___unrestricted

Physical Build:…………………___Heavy set………………… ___medium……….. ___muscular……… ___obese…………..___slight

Physical Fitness:……..………. ___athletic……………………. ___fair…………….. ___good……………___poor……………___athletic

Race:……………………………___African American…………___Asian American ___Caucasian……. ___Native American
___Other_______________

Posture: ___antalgic…………___erect……………___guarded……… ___Head and neck held erect……………___left anterio-lateral flexion antalgia
___left lateral antalgia…………………… ___right anterio-lateral flexion antalgia…………………………___right lateral antalgia
___stooped…………………………………………… ___thoracal lumbar posture is erect

Mental: ___anxious……….. ___excitable………___nervous……….. ___nervous driving……………___neurotic……….. ___N/A

Prognosis ___Good……… ___Fair……………. ___Guarded………. ___Poor…………… ___Other (custom)______________________________

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