FOUNDATIONAL
Wellness Center

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Welcome to our office!

It is our pleasure to serve you today. To help us better understand your needs, please answer the following questions:

Your Name _____ Date_____

MY PURPOSE FOR TODAY'S APPOINTMENT IS:

(Please check all that apply to you)

☐ I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and wellbeing as well as preventing future problems.

☐ I'm here for an evaluation because I'm having health challenges and am looking for a natural health solution.

☐ I'm here for an evaluation. I want to know if my spine is healthy and to see if I have any problems that I don't know about.

☐ I am here for an evaluation because I would like to learn more about Chiropractic Care.

☐ I am here for an evaluation only.

☐ Other _____

_____

IF THE DOCTORS FEEL THAT THEY CAN HELP YOU:

(Please check the one that best applies to you)

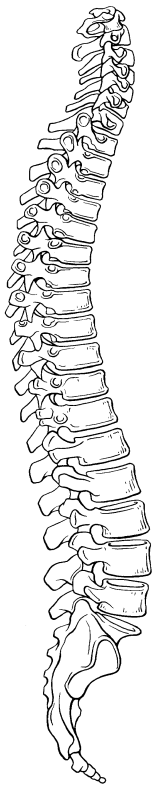
☐ I am willing to follow the doctor's recommendations because I strongly value my health.

☐ I am not interested in receiving any care.

About Your Child…

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Our purpose is to care for and educate as many families as possible towards optimal health. Spinal subluxation destroys an optimal spine and your ability to have optimal health. Your experience with this office will not only be one of healing, but also of learning about optimal health and healing.



Name _____ Home Phone _____

Mother's Name: _____ Father's Name: _____ Marital Status: _____

Address _____ Cell Phone _____

City, State, Zip _____

Birth date _____ Age _____ Grade _____

E Mail Address _____

To conserve resources we generally utilize Email for regular communication.

May we communicate with you via Email? ☐ YES ☐ NO

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? _____ ☐ Never

3. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup or other device? (Please circle) ☐ YES ☐ NO

4. How long was the actual labor and delivery time? _____

During the birth, did the mother have any epidural or receive any medication?

☐ YES ☐ NO Comments _____

5. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO _____

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Did your child have early health challenges such as colic or frequent ear infections?

☐YES ☐NO _____

8. Does your child suffer from any of the following: allergies, sinus problems, bed-wetting, difficulty concentrating, attention deficit disorder? (Please circle)

9. Please list any health symptoms or health complaints your child is experiencing.

1. _____ 2. _____ 3. _____

10. What is your motivation to seek/receive care in this office for your child?

_____

11. Do you miss work or sleep often due to your child's illnesses? ☐ YES ☐ NO

12. Do you worry often about your child's health? ☐ YES ☐ NO

13. Do you any have health problems that affect your family? Please list _____

_____

14. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications is your child currently taking?

_____

15. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury? ☐ YES ☐ NO Date of Incident _____

16. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations? ☐ YES ☐ NO

The above information is true and accurate to the best of my knowledge.

Signature of Parent or Guardian_____ Date_____

We thank you for allowing us the privilege of being an integral part of your child's health and well being. We consider this the utmost expression of faith and will give your child the highest degree of clinical excellence that we can provide.

Foundational Wellness Center
Parental Consent Form

Dr. Jim Bentley, D.C.
(855) 692-4470

I, _____, being the parent/legal guardian (circle one) of _____, do hereby grant permission for him/her to receive care from Dr. Jim Bentley, D.C. at the Foundational Wellness Center. This should include, when necessary, standard spinal analysis, appropriate assessment procedures and spinal adjustments.

_____

Parent or Legal Guardian Signature Date

_____

Witness Signature Date

REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less then optimal function.

Check either **I DENY having/had** OR **Circle P for PAST** OR **Circle N for NOW**

CONSTITUTIONAL

❒ **I DENY** having or having had any of the **symptoms or problems listed below.**

P N chills
P N daytime drowsiness
P N fatigue
P N fever
P N night sweats
P N weight gain
P N weight loss

EYES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Wear glasses or contact lenses
P N blindness
P N Cataracts
P N Glaucoma

EARS / NOSE / THROAT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Difficulty/Loss of hearing
P N Ringing in the ears (tinnitus)
P N Frequent ear aches
P N Discharge from the ear
P N Attacks of vertigo
P N Sinus trouble
P N Nasal blockage
P N Frequent sneezing
P N Frequent sore throat
P N Snoring
P N Recent change in voice quality
P N Sleep apnea
P N Difficulty in swallowing
P N Nose bleeds

RESPIRATORY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Asthma or wheezing
P N Recent bronchitis or chest cold
P N Cough
P N Coughing up blood
P N Shortness of breath

HEART & CIRCULATION

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Heart attack
P N High blood pressure
P N Heart murmur
P N Chest discomfort (angina)
P N Heart failure or fluid on the lungs
P N Palpitations, racing or pounding
P N Shortness of breath w/activity
P N Stroke / mini stroke or TIA
P N Blood clot in artery or vein
P N "Black out spells"
P N Aneurysm of any blood vessel
P N Swelling of legs
P N Heart surgery
P N Heart palpitations

STOMACH / INTESTINES

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Ulcer
P N Frequent heartburn or indigestion
P N Hiatal hernia and or acid reflux
P N Poor appetite
P N Gall bladder attacks
P N Frequent diarrhea
P N Chronic constipation
P N Bright blood bowels or rectum
P N Abnormal stool
P N Liver disease or jaundice

ENDOCRINE / METABOLISM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Thyroid disorder
P N Unusual hair loss or growth
P N goiter
P N Diabetes

KIDNEYS / URINARY TRACT

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Kidney disease or failure
P N History of kidney dialysis
P N Kidney stones or infection
P N Pain or burning with urination
P N Trouble starting urinary stream
P N Dribbling or incontinence
P N Frequent Night Urination
P N Bladder infections during past year
P N Blood in urine during past year

MUSCLES / BONES / JOINTS

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Arthritis or other joint disease
P N Chronic back trouble
P N Bone or joint surgery in past year

ALLERGY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N anaphylaxis
P N food intolerance
P N itching
P N nasal congestion
P N rash
P N sneezing

SKIN

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Rashes, psoriasis or dermatitis
P N History of skin cancer
P N New skin growth or mole

NERVOUS SYSTEM

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Headache
P N Epilepsy or seizures
P N Date of last seizure:_____
P N Depression
P N Other nervous disorder
Specify:_____

PSYCHOLOGIC

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N anxiety
P N loss or change in appetite
P N behavioral change
P N bi-polar disorder
P N confusion
P N convulsions
P N depression
P N insomnia
P N memory loss
P N mood change

BLOOD

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Bleeding or bruising tendency
P N Previous blood transfusion
P N History of hepatitis

MEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Testicular swelling
P N Prostate Problems
P N Frequent urination

WOMEN ONLY

❒ **I DENY** having or having had any of the symptoms or problems listed below.

P N Painful periods
P N Excessive Flow
P N Irregular cycles
P N Vaginal Burning
P N Hot Flash
Are you pregnant? Yes No

Past Medical and Family History

Surgical History: (NONE)

Hospitalization History: (NONE)

Allergy History: (NONE)

Please circle the following diseases if your family members (blood relatives) have experienced them:

Diabetes Cancer High Blood Pressure Allergy Hearing Loss Stroke Bleeding Disorder

List any other illness that "runs in your family" (blood relatives):

HEIGHT _____ **WEIGHT**_____ **BLOOD PRESSURE** _____ **PULSE**_____ ❑ N/A MINOR

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____ Date: _____

Health Symptom/Complaint Questionnaire

Three Types of Care

1.Relief/Crisis Care
Temporary Relief
Many people begin here. Their ache, pain, or other obvious symptom is often what prompts them to begin chiropractic care. Careful! If you stop care as soon as you feel better, before muscles and soft tissues heal, you can invite needless relapse.

2.Corrective Care
Keep Your Health
Regular chiropractic care can help maintain your progress and avoid a relapse. Your visit schedule will vary based on your age, condition and the stresses in your life. The intention is to help you preserve your progress so far.

3.Wellness Care
Being Your Best
Simply put, we experience our lives through our nervous system. That's why optimizing our spines and nervous systems is the key to health and becoming all that we can be. Chiropractic care and other healthy habits create new possibilities.

Your Health Affects Everything You Do and Everyone You Know
With so many people depending on you it makes sense to invest wisely in your health!

Our purpose is to care for and educate as many families as possible towards optimal health! Subluxations cause spinal decay that destroys an optimal spine and your ability to have optimal health. Your experience with this office will not only be one of healing, but also of learning about optimal health and maximizing your healing.

Issue #1 _____

1. **When did this start?/How long have you had this issue?**
   _____
2. **How is this issue affecting your,**
   Work_____
   Life Style_____
   Hobbies_____
   Relationships_____
   Other_____
3. **What have you done in the past to permanently resolve this issue?**
   _____
4. **Has anything you've done resolved this issue?**
   _____
5. **In your opinion what is the reason none of these things you've tried in the past have worked?**
   _____
6. **How do you feel about that?**
   _____

Issue #2 _____

1. **When did this start?/ How long have you had this issue?**
   _____
2. **How is this issue affecting your,**
   Work_____
   Life Style_____
   Hobbies_____
   Relationships_____
   Other_____
3. **What have you done in the past to permanently resolve this issue?**
   _____
4. **Has anything you've done resolved this issue?**
   _____
5. **In your opinion what is the reason none of these things you've tried in the past have worked?**
   _____
6. **How do you feel about that?**
   _____

Issue #3 _____

1. **When did this start?/How long have you had this issue?**
   _____
2. **How is this issue affecting your,**
   Work_____
   Life Style_____
   Hobbies_____
   Relationships_____
   Other_____
3. **What have you done in the past to permanently resolve this issue?**
   _____
4. **Has anything you've done resolved this issue?**
   _____
5. **In your opinion what is the reason none of these things you've tried in the past have worked?**
   _____
6. **How do you feel about that?**
   _____

NOTICE OF PRIVACY PRACTICES

Dr. Jim Bentley, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

We have a website that provides information about us. For your benefit, this notice is on the website at this address:
www.networkwellnesscenters.com

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dr. Jim Bentley, D.C., (855) 692-4470

Sign; _____

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr. Jim Bentley, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON June 1st, 2004.

Foundational Wellness Center
www.foundationalwellnesscenter.com
(855)692-4470

Notice of Privacy Practices -- Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Jim Bentley, D.C.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

As required by the privacy regulations, I am aware that Foundational Wellness Center has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

By my signature below I acknowledge receipt of the Notice of Privacy Practices, I provide Foundational Wellness Center, with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice

_____ _____
Signature of patient or authorized representative Date

_____ _____
Printed name if signed on behalf of patient / Relationship (parent, legal guardian, personal representative, etc.)

(Notation, if any, by staff)

This form will be retained in your health record.

INFORMED CONSENT

This office practices evidence based spinal care. This practice is based on nationally recognized practice guidelines as well as published research conducted at numerous universities and chiropractic colleges. Our commitment to you is to deliver the safest, highest quality of life changing care we can deliver focused on the reduction of spinal cord tension, spinal subluxations and to develop and maintain spinal and neural integrity.

To begin care, we need your consent to perform a history and physical evaluation focused on testing procedures and questions that solely relate to quality of life, stress levels, body awareness, spinal cord tension, spinal subluxations and the loss of spinal and neural integrity. The intent of your evaluation is to assess your current level of spinal and neural integrity. From there we will be able to create a plan to maximize your quality of life and degree of well being.

We will not be performing a differential diagnosis to detect the presence of or determine target treatment for any disease, condition or symptom. The only diagnosis we will provide is that of spinal subluxation. If you desire advice, diagnosis or treatment for any symptom, condition, disease or concern we recommend that you seek the services of a health care provider who specializes in that area.

I _____ have read and fully understand the above statements. I understand that the spinal adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and nerve system integrity. This office offers chiropractic as a form of health and wellness care, to promote the natural mechanisms for self healing and empowerment, as compared to specific target treatment. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Cancellation Cost

We are here to help as many people as possible.

Unfortunately, we can only fit a certain number of people in our office per day. We have a large waiting list with people in pain.

Therefore, if you are unable to make your appointment please let us know **24** hours in advance. If you fail to do so we will be billing you for the price of your visit.

X _____ X _____

Sign Date

Thank you for understanding!