"Leading people to wellness by teaching and healing naturally."
~ Dr. David Budaj

Bloomfield Wellness Clinic: Dr. David D Budaj
5799 West Maple Rd., Ste 159, West Bloomfield, MI 48322
Tel: 248·626·0001 Fax: 248·626·0008

APPLICATION FOR CARE

Today's Date: _____

PATIENT DEMOGRAPHICS

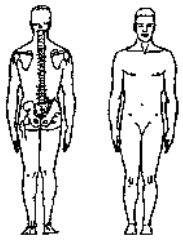
Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐Male ☐Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Mobile Phone:_____
Work Phone: _____ Do you have Insurance: ❑Yes ❑No Marital Status: ❑Single ❑Married
# of children: _____ May we contact you via text message to keep aware of future appointments? ❑Yes ❑No
Social Security #: _____ Driver's License #: _____
Employer: _____ Occupation: _____
Spouse's Name ❑(N/A)_____Spouse's Employer _____
Who May We Thank For Referring You? _____❑Mailer ❑TV ❑Internet ❑Dinner ❑Other:_____
Name & Number of Emergency Contact: _____ _____
Relationship: _____

CHIROPRACTIC HISTORY

When/ and where was your last complete spinal examination including x-rays? _____ _____ ❑Never
Over time, spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? ❑Yes ❑No
If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back.
Do you often feel the need to crack or pop your neck or lower back? ❑Yes ❑No
Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent
Stress will cause you to accelerate spinal damage. Rate your stress level. Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and how they happened:
Primary: _____ _____ Second: _____ _____
Third: _____ _____ Fourth: _____ _____
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**
Primary or chief complaint is: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Second complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Third complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Fourth complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
When is the problem at its worst? ☐AM ☐PM ☐Mid-day ☐Late PM
How long does it last? ☐It is constant **OR** ☐I experience it on and off during the day **OR** ☐It comes and goes throughout the week
***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____
What makes them feel worse? _____
Is your problem the result of ANY type of accident? ☐Yes ☐No
Please identify any other injury(s) to your spine, minor or major, that the doctor should know about:
_____

If your complaints get in the way of doing things in your life please list those activities below.

LIST AFFECTED ACTIVITIES: CURRENT RESTRICTION LEVEL (Time/ Amount) SUCCESS GOAL

Ex: Driving long distances : Begins to hurt after 30 Minutes To drive long distances w/ no pain
_____: _____ _____
_____: _____ _____
_____: _____ _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑No ❑Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____
Have you ever been treated by anyone for this in the past? ☐No ☐Yes **If yes,** when: _____
by whom?_____For how long was the care: _____
How long ago? _____**If yes,** please state **what** type of treatment: _____,
What were the results. ☐Favorable ☐Unfavorable→
please explain._____
_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular Other serious conditions:_____

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST SIX MONTHS:

Musculoskeletal:
- ☐ General Stiffness
- ☐ General Weakness
- ☐ Swollen Joints
- ☐ Spinal Curvature
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Pain between Shoulders
- ☐ Low Back Pain
- ☐ Foot Trouble
- ☐ Walking Problems
- ☐ Jaw Problems

Nervous System:
- ☐ Nervous
- ☐ Numbness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Twitching

General:
- ☐ Fatigue
- ☐ Allergies
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Thyroid Problems

Gastrointestinal:
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Vomiting
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramping
- ☐ Gas/Bloating/Belching
- ☐ Heartburn
- ☐ Bloody/Black Stools
- ☐ Colitis

CVR:
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT:
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Frequent Colds
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Hoarseness

Genitourinary:
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

Female:
- ☐ Cramps
- ☐ Irregular Periods
- ☐ Painful Periods

PLEASE IDENTIFY ALL PAST and any CURRENT:

INJURIES / ACCIDENTS →_____
MOTOR VEHICLE ACCIDENTS →_____
SURGERIES →_____
CHILDHOOD DISEASES →_____
MEDICATIONS (name/reason/how long for each)→_____
_____
_____
_____
ALLERGIES→_____
_____
_____
_____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑pipe ❑cigarettes → How often? ❑Daily ❑Weekends ❑Occasionally ❑Never
2. Alcoholic Beverage: consumption occurs → ❑Daily ❑Weekends ❑Occasionally ❑Never
3. Recreational Drug use: ❑Daily ❑Weekends ❑Occasionally ❑Never
4. Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White (Caucasian)
❑Native Hawaiian or Pacific Islander ❑I Decline to Answer
5. Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑No ❑Yes
If yes whom: ❑grandmother ❑grandfather ❑mother ❑father ❑sister's ❑brother's ❑son(s) ❑daughter(s)
Have they ever been treated for their condition? ❑No ❑Yes ❑I don't know
2. Any other hereditary conditions the doctor should be aware of: ❑No ❑Yes: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

BLOOMFIELD WELLNESS

"Leading people to wellness by teaching and healing naturally." ~ Dr. David Budaj

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by **Bloomfield Wellness Clinic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.

(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible $25.00 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Missed Appointment Policy

December 3, 2016

Our goal is to provide quality individualized care in a timely manner. Missed appointments and late cancellations inconvenience those individuals who need access to care in a timely manner. We would like to inform you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of treatment. When a patient cancels without giving enough notice, they prevent another patient from being seen and more simply, a patient who misses an appointment fails to get necessary treatment.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment by **3:00 p.m.** on the day prior to your scheduled appointment. To cancel a *Monday* appointment, please call our office by 3:00 p.m. on *Friday*.

Missed Appointments:

A missed appointment is considered when a patient is more than 15 minutes late for their scheduled appointment.

With the exception of serious emergencies it is expected that you keep all your appointments.

- *First Offense* will result in a **warning**.
- *Second Offense* will result in a **$25 fee** that will need to be paid before you are seen.

We at Bloomfield Wellness Clinic appreciate you greatly as our patient, and we appreciate your commitment to maintain the highest standards of healthcare on your behalf and on behalf of all of Bloomfield Wellness Clinic's patients. We hope that this policy is understood by our patients as a means to ensure that every appointment is treated as important and valuable.

I have read and fully understand the Bloomfield Wellness Clinic Missed Appointment Policy.

Patient's Name_____ Date _____
Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____