Original

HealthTrac Family Wellness

Patient History Information

Please complete this form and then return to the receptionist.
Por Favor complete esta forma y regresela a la recepcionista.

- Please PRINT -

Date/ *Fecha*: ____________ Patient No: ____________

Last Name *Apellido*: ____________ **First and Middle Name** *Primer Nombre*: ____________ **Height**: *Altura*: ___' ___"

Age/ *Edad*: ______ **Date of Birth**/ *Fecha de Naciemiento*: ______ ❑ **Male**/*Masculino* ❑ **Feimale**/*Femenino* **Weight**: *Peso*: ______ lb.

Home Address/ *Direccion*: ________________________

City/ *Ciudad*: ____________ **State**/ *Estado*: ____ **Zip Code**/ *Postal*: ________

Telephone *Telefono*: **Home** *Casa*: ____________ **Work** *Trabajo*: ________ **Mobile** *Celular*: ________

Social Security # *Seguro Social*: ____________ **Email** *Email* : ____________

Occupation/ *Ocupaccion*: ____________ **Employer**/*Empleador*: ____________

❑ **Full-Time Job** *Empleado* ❑**Part-Time Job** *Medio Tiempo* ❑ **Multiple Jobs** *Multiples Trabajos* ❑**Employed** *Trabajador Independiente* ❑ **Retire** *Retirado* ❑ **Suspended** *Suspendido* ❑**Unemployed** Desempleado

Work Address/ *Direccion de Trabajo*: ________________________

City/ *Ciudad*: ____________ **State**/ *Estado*: ________ **Zip code**/ *Postal*: ________

Marital Status/ *Estado Marital*: ❑ **Single**/*Soltera* ❑ **Married**/*Casada* ❑ **Divorced**/ *Divorciada* ❑ **Widowed**/*Viuda*

Spouse's Name Nombre Esposo: ____________ **Number of Children** *Numero de Hijos*: ________ **Ages** *Edades*: ________

Phone Number/ *Telefon* ____________

Emergency Contact Person/ *Contacto de Emergencia*: ____________ **Phone Number**/*Telefono*: ____________

Have you received chiropractic care in the past? *Ha recibido cuidado chiropractico en el pasado ?* ❑ **Yes**/*Si* ❑ **No**/ *No* **When?** *Cuando?* ________

If yes, please give name of the Chiropractor: *Si es si, Proveame el nombre del chiropractor*: ________________________

Please describe the reason for previous care: *Por Favor describame la razon de su anterior cuidado:* ________________________

Name of your Medical Doctor *Nombre de su Doctor:* ________________________

List the name of your health insurance company: *Nombre su aseguranza medica:* ________________________

Policy number is: *Numero de la poliza:* ________________________

Reason(s) for seeking chiropractic care starting with the most severe:
Razones por la que busca cuidado chiropractico empieze por el mas severo

Chief Complaint *Motivo de la Consulta*	**Approximate Date Started** *Dia que Empezo*
1. ______	______
2. ______	______
3. ______	______

Areas of injury or discomfort:
Areas que tiene el dano o la molestia

On the following chart please mark area(s) of injury or discomfort (see example). Mark all areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).
En el dibujo abajo marque el area que tiene el dano o que le molesta (vea el ejemplo) Marque todas las areas apropiadamente con simbolo indicando el dolor empezando con 1 (molestia) con 10 (extremo dolor)

Example
BBBB 5
SSSS 9
left right

NNNN **Numbness** entumecimiento
PPPP **Pins & Needles** *hormigueo*
BBBB **Burning** *ardor*
AAAA **Aching** *Dolor*
SSSS **Stabbing** *Punalada*

Circle any area of pain not represented by a symbol.
Circule el area de dolor representada por el simbolo

Right — Front (right, left) — Back (left, right) — Left

Please indicate any medications you are currently taking:
Porfavor indique cualquier medicamento que usted este actualmente tomando:

- ❑ **Blood pressure/** *Presion*
- ❑ **Muscle relaxants/** *Relajente Muscular*
- ❑ **Stimulants/** *Estimulante*
- ❑ **Blood thinners/** *Anticoagulante*
- ❑ **Steroids/** *Esteroides*
- ❑ **Birth control** *pills/ Anticopcetiva*
- ❑ **Stimulants/** *Estimulantes*
- ❑ **Pain killers** (*including Aspirin*)
- ❑ **Insulin/** *Insulina*
- ❑ **Antibiotics/** *Antibiotico*
- ❑ **Sleeping Pills/** *Pastilla para dormir*

❑ **Others** /*Otras*: ______

Name of nutritional supplements and/or dietary aids:
Alguna nutricion suplementaria o ayuda para la alimentacion: ______

Revision de los sistemas, Por favor anote cualquier condicion que halla tenido en el pasado que que tenga ahora:

Now	Past		Now	Past		Now	Past	
☐	☐	**Back Pain** *Dolor espalda*	☐	☐	**Chest Pain** *Dolor de Pecho*	☐	☐	**Difficulty Urinating** *Dificultad para Orinar*
☐	☐	**Neck Pain** *Dolor cuello*	☐	☐	**Poor Circulation** *Poca Circualcion*	☐	☐	**High BP** *Presion Alta*
☐	☐	**Shoulder/Arm Pain** *Dolor de Hombro*	☐	☐	**Skin Problems** *Problema de piel*	☐	☐	**Arrhymia** *Arritmia*
☐	☐	**Hip/Leg Pain** *Dolor de pierna y cadera*	☐	☐	**Colon Trouble** *Problemas del colon*	☐	☐	**Frequent Infections** *Infecciones*
☐	☐	**Sciatica** *Ciatica*	☐	☐	**Stomach Trouble** *Problema del Estomago*	☐	☐	**Difficulty Breathing** *Dificulatad para respirar*
☐	☐	**Arthritis** *Arthritis*	☐	☐	**Kidney Problems** *Problema de los rinones*	☐	☐	**Liver Trouble** *Problema del higado*
☐	☐	**Asthma** *asma*	☐	☐	**Easy Bruising** *Hematomas*	☐	☐	**Pregnancy** *Embarazada*
☐	☐	**Prostate Problems** *Problema de la prostata*				☐	☐	**Menstrual Problems** *Problema menstrual*
☐	☐	**None of the above** *Ninguno*	☐	☐	**None of the above** *Ninguno*	☐	☐	**None of the Above** *Ninguno*

Have you ever: *Alguna vez:*

Comments: *Comentarios:*

Had any accidents, falls, traumas, or injuries:
accidentes、caidas、traumas : ☐**Yes**/*Si* ☐ **No** ____________________

Been hospitalized/ *Ha estado Hospitalizado* : ☐ **Yes**/*Si* ☐ **No** ____________________

Had a broken bone / *Algun hueso roto:* ☐ Yes/*Si* ☐ **No** ____________________

Had surgery / *Ha tenido cirugia:* ☐ **Yes**/*Si* ☐ **No** ____________________

Been treated for an emotional disorder
Ha estado en tratamiento para un trastorno emocional: ☐ Yes/*Si* ☐ No ____________________

Been bedridden for more than a week
Ha estado postrado en una cama por mas de una semana: ☐ Yes/*Si* ☐ No ____________________

Health/Risk Factors / *Riesgo de Salud Factores:*

Comments / *Comentarios:*

Do you smoke? *Fuma*? ☐ **Yes**/*Si* ☐ **No** If yes ☐ ☐ Occasional ☐ Light ☐ Medium ☐ Heavy

Do you drink alcohol? *Toma alcohol* ☐ **Yes**/*Si* ☐ **No** If yes ☐ Once/Week ☐ 2-5 Times/Week ☐ Daily

Do you have a healthy diet?
Tiene una dieta saludable ? ☐ **Yes**/*Si* ☐ **No** ____________________

Do you exercise regularly?
Hace ejercicios regulares ? ☐ **Yes**/*Si* ☐ **No** If yes ☐ Occasional ☐ 3-5 Times/Week ☐ Daily

Do you sleep well? *Duerme bien ?* ☐ **Yes**/*Si* ☐ **No** ____________________

Is your job stressful?
Es su trabajo estresante ? ☐ **Yes**/*Si* ☐ No ____________________

Do you drink caffeine? *Tomas cafeina*? ☐ Yes/*Si* ☐ No If yes If yes ☐ Occasional ☐ Daily

What is your dominate hand?
Cual es tu mano dominate? ☐ **Right** / *Derecha* ☐ **Left** / *Izquierdo* ☐ **Both** /*Ambidextro*

Can you think of any other habit or activity that has a positive or negative effect on your health? ☐ **Yes**/*Si* ☐ No
Puede usted pensar en otra actividad o habito que le produzca un efecto negativo o positivo en su salud?

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________ ______________________________ ______________

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, ________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________________________________

____ ____________________

Signature Date

HealthTrac Family Wellness, Inc

On Track to Great Health

Consent For Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **HealthTrac Family Wellness** (also HTFW) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **HTFW**. I understand that diagnosis or treatment of me by **Dr. George Hui, D.C.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **HealthTrac Family Wellness** is not required to agree to the restrictions that I many request. However, if **HTFW** agrees to a restriction that I request, the restriction is binding on **HTFW** and **Dr. George Hui, D.C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. George Hui, D.C.** or **HTFW** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **HTFW**'s Notice of Privacy Practices prior to signing this document. The **HTFW**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of **HTFW**. This Notice of Privacy Practice also describes my rights and **HTFW**'s duties with respect to my protected health information.

HealthTrac Family Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

________________________________ ________________________________

Signature of Patient or PR/ Date Please Print Name of Patient or PR

____

Description of Personal Representative's Authority

HealthTrac Family Wellness, Inc.

Authorization for Use or Disclosure of Information for Purposes Requested by Chiropractor

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to HealthTrac Family Wellness.

I hereby authorize Chiropractor to (check those that apply):
_____ use the following protected health information, and/or
_____ disclose the following protected health information to the following entity:

____

Information to be used or disclosed:
Date of service: ____
Type of service: ____
Level of detail to be released: _________________________________
Origin of information: ____

This protected health information is being used or disclosed for the following purposes:

____

This authorization shall be in force and effect until _____________________________,
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer of the Chiropractor, at 4720 Peachtree Industrial Blvd. Suite 104, Norcross, GA 30071. I understand that a revocation is not effective to the extent that Chiropractor has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Chiropractor will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this authorization.

_________________________________ _________________________________
Signature of Patient or Personal Representative | Printed Name of Patient

_________________________________ _________________________________
Date of Signing | Description of Personal Representative's Authority

Personal Injury Consultation Form
Forma para consultar su Lesion Personal

Name: *Nombre:* ______________________ **Date:** *Fecha:* ______________________

Date of Accident:
Dia que ocurrio el accidente: ______________________

1. **At impact did you experience a flash in your head?** ______**Yes** / *Si*
   Cuando recibio el impacto siento mareo o calentura ? ______ **No** / *No*
   Did you lose consciousness? _____**Yes** / Si
   Perdio el conocimiento? _____**No** / No
2. **Immediately following the accident how did you feel?**
   Inmediatamente siguiendo el accidente como se sintio, explique por favor ?
   ____
   Did you become? (Please circle)
   Que ha sentido ? (Por favor circule sus respuestas)
   Confused/ *Confundido*, **Disoriented/** *Desorientado*, **Light headed/** *Mareado,* **Nauseated/** *Nauseas,*
   Blurred vision/ *Vision borrosa*, **Ringing/Buzzing in ears/** *Zumbido en los timpanos*
3. **Are you currently experiencing? (Please circle)**
   Que esta actualmente experimentando ? (Por Favor circule su respuesta)
   Restlessness/ *Inquietud*, **Irritable/** *Irritabilidad*, **Difficulty concentrating and remembering/** *Dificultad para concentrarse y recorder,* **Sleeplessness** / *Insomnio,* **Forgetfulness** / *Olvida muy rapidamente*,
   Reduced tolerance to heat or cold/ *No tolera el caliente ni el frio*
4. **Over the next few hours and days, what symptoms did you feel?**
   En las proximas horas y dias, que sintomas ha tenido ?
   ____
   ____
   ____
5. **Please tell us how your accident happened.**
   Cuéntenos cómo ocurrió su accidente:
   ____
   ____
   ____
   ____
   ____
6. **Were you wearing a seatbelt?** Estabas usando el cinturón de seguridad?
   ____
7. **Was your car moving at impact?** **How fast?**
   Su carro estaba en movimiento al recibir el impacto? _____**Yes** / *Si* _____**No/** *No* *Que tan rapido ?* ____________.
8. **Did airbags deploy?** **Which ones?**
   Se desplegaron los airbags? _____**Yes** / *Si* ___**No/** *No* *Cuáles ?* ____________________.
9. **Were you the driver?** **If not, where were you sitting?**
   Eras tú el conductor? _____*Yes / Si* ___*No/ No* *dónde estabas sentado?* ____________________
10. **Which way was your body facing at impact?** **Straight** **Right** **Left**
    En que posicion estaba su cuerpo cuando recibio el impacto? ___ *Derecho* ____*Derecha* ____*Izquierda*
11. **Which way was your head facing at impact?** **Straight** **Right** **Left**
    En que direccion estaba su cabeza cuando recibio el impacto? ___ *Derecho* ____*Derecha* ____*Izquierda*
12. **Were you surprised by the impact**
    Fue usted sorprendido por el impacto ? _____**Yes** /*si* _____**No** / *No*
13. **Does your car have a headrest?**
    Tiene su carro un cabezal ? _____**Yes** /*si* _____**No** /*No*
14. **Had this collision affected your work, hobby, or social activities?**
    Esta colisión afectó su trabajo, pasatiempo o actividades sociales? ____________________

Neck Disability Index 颈部伤害指数

Patient Name 姓名: ____________________

Date日期: ____________________

1. Pain Intensity 疼痛强度

☐ I have no pain at the moment 我现在没有疼痛	+0
☐ The pain is very mild at the moment 目前疼痛轻微	+1
☐ The pain is moderate at the moment 目前疼痛中等	+2
☐ The pain is fairly severe at the moment 目前疼痛比较严重	+3
☐ The pain is very severe at the moment 目前疼痛非常严重	+4
☐ The pain is the worst imaginable at the moment 目前的疼痛是可以想象的最痛的程度	+5

2. Personal Care (Washing, Dressing, etc.) 个人护理（梳洗，穿衣等等）

☐ I can look after myself normally without causing extra pain 可以正常自理不会造成额外的疼痛	+0
☐ I can look after myself normally but it causes extra pain 可以正常自理但会造成额外的疼痛	+1
☐ It is painful to look after myself and I am slow and careful 照理自已时有疼痛，我会緩慢而小心	+2
☐ I need some help but can manage most of my personal care 我需要一些幫助，但大部分可以自理	+3
☐ I need help every day in most aspects of self care 我每天在自理方面大部分都需要幫助	+4
☐ I do not get dressed, I wash with difficulty and stay in bed 我无法穿衣服，洗漱有困難，並保持卧床	+5

3. Lifting 提重

☐ I can lift heavy weights without extra pain 我可以提重物而不會感到額外的疼痛	+0
☐ I can lift heavy weights but it gives extra pain 我可以提重物，但會帶來額外的疼痛	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table 疼痛使我無法將重物從地板上抬起，但如果它們放在方便的位置，比如在桌子上，我就可以抬起	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned 疼痛使我無法提起重物，但如果它們放在方便的位置，我可以提起輕到中等的重物	+3
☐ I can only lift very light weights 我只能提起很輕的重量	+4
☐ I cannot lift or carry anything 我無法舉起或攜帶任何東西	+5

4. Reading 閱讀

☐ I can read as much as I want to with no pain in my neck 我可以想讀多少就讀多少，脖子不會感觉到疼痛	+0
☐ I can read as much as I want to with slight pain in my neck 我可以隨心所欲地閱讀，但頸部会有輕微疼痛	+1
☐ I can read as much as I want with moderate pain in my neck 我可以隨心所欲地閱讀，但頸部会有中度疼痛	+2
☐ I can't read as much as I want because of moderate pain in my neck 由於頸部的中度疼痛，我無法隨心所欲地閱讀	+3
☐ I can't hardly read at all because of severe pain in my neck 由於頸部的劇烈疼痛，我幾乎無法閱讀	+4
☐ I cannot read at all 我完全無法閱讀	+5

5. Headaches 頭痛

☐ I have no headaches at all 我完全沒有頭痛	+0
☐ I have slight headaches, which come infrequently 我有輕微的頭痛，但痛的次数很少	+1
☐ I have moderate headaches, which come infrequently 我有中度頭痛，但痛的次数很少	+2
☐ I have moderate headaches, which come frequently 我經常出現中度頭痛	+3
☐ I have severe headaches, which come frequently 我經常有嚴重的頭痛	+4
☐ I have headaches almost all the time 我幾乎總是頭痛	+5

6. Concentration 專注力

☐ I can concentrate fully when I want to with no difficulty 當我需要的時候我可以毫無困難地完全集中註意力	+0
☐ I can concentrate fully when I want to with slight difficulty 當我需要的時候，我可以完全集中註意力，但有一點困難	+1
☐ I have a fair degree of difficulty in concentrating when I want to 當我需要集中註意力的時候，我有相當大的困難	+2
☐ I have a lot of difficulty in concentrating when I want to 當我想要集中註意力時，我很難集中註意力	+3
☐ I have a great deal of difficulty in concentrating when I want to 當我想要集中註意力時，我极度難以集中註意力	+4
☐ I cannot concentrate at all 我根本無法集中註意力	+5

7. Work 工作

☐ I can do as much work as I want to 可以工作想做多少就多少	+0
☐ I can only do my usual work, but no more 我只能做我日常的工作，但不能做更多的事情	+1
☐ I can do most of my usual work, but no more 我可以做大部分日常的工作，但不能做更多的	+2
☐ I can't do my usual work 我無法做我日常的工作	+3
☐ I can hardly do any work at all 我幾乎無法做任何工作	+4
☐ I can't do any work at all 我根本無法做任何工作	+5

8. Driving 駕駛

☐ I can drive my car without any neck pain 我可以開車而不會感覺到頸部疼痛	+0
☐ I can drive my car as long as I want with slight pain in my neck 我可以隨心所欲地開車，但頸部會有輕微疼痛	+1
☐ I can drive my car as long as I want with moderate pain in my neck我可以隨心所欲地開車，但頸部有中度疼痛	+2
☐ I can't drive my car as long as I want because of moderate pain in my neck由於頸部中度疼痛，我無法隨心所欲地開車	+3
☐ I can hardly drive at all because of severe pain in my neck 由於頸部劇烈疼痛，我幾乎無法開車	+4
☐ I can't drive my car at all 我根本無法開車	+5

9. Sleeping 睡眠

☐ I have no trouble sleeping 我睡覺沒有問題	+0
☐ My sleep is slightly disturbed (less than 1 hr sleepless) 我的睡眠受到輕微干擾（失眠時間少於 1 小時）	+1
☐ My sleep is mildly disturbed (1-2 hrs sleepless) 我的睡眠受到輕微干擾（1-2 小時失眠）	+2
☐ My sleep is moderately disturbed (2-3hrs sleepless) 我的睡眠受到中度干擾（2-3 小時失眠）	+3
☐ My sleep is greatly disturbed (3-5 hrs sleepless) 我的睡眠受到很大干擾（3-5小時失眠）	+4
☐ My sleep is completely disturbed (5-7 hrs sleepless) 我的睡眠完全受到干擾（5-7 小時失眠）	+5

10. Recreation 娛樂

☐ I am able to engage in all recreational activities with no neck pain at all 我能夠參加所有娛樂活動，頸部完全不會疼痛	+0
☐ I am able to engage in all my recreational activities, with some pain in my neck 我可以參加所有的娛樂活動，但頸部会有些疼痛	+1
☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck 由於頸部的疼痛，我只能參加我的大部分日常娛樂活動	+2
☐ I am able to engage in a few of my usual recreational activities because of pain in my neck 由於頸部疼痛，我只能參加一些日常的娛樂活動	+3
☐ I can hardly do any recreational activities because of pain in my neck 由於頸部疼痛，我幾乎無法參加任何娛樂活動	+4
☐ I can't do any recreational activities at all 我根本無法參加任何娛樂活動	+5

Total Score:

Raw Score: Summation of Points

Raw Score: ______ Points

Percentage Score: $\frac{\text{Raw Score}}{\text{\# Completed Questions} * 5}$

Percentage Score: ______ %

Oswestry Disability Index (ODI) 腰背痛

Patient Name: ______________________

Date: ______________________

1. Pain Intensity 疼痛強度

☐ I have no pain at the moment 我現在沒有疼痛	+0
☐ The pain is very mild at the moment 目前疼痛輕微	+1
☐ The pain is moderate at the moment 目前疼痛中等	+2
☐ The pain is fairly severe at the moment 目前疼痛相當嚴重	+3
☐ The pain is very severe at the moment 目前疼痛非常嚴重	+4
☐ The pain is the worst imaginable at the moment 目前的疼痛是可以想像到的最嚴重的程度	+5

2. Personal Care (Washing, Dressing, etc.)

个人护理（梳洗，穿衣等等）

☐ I can look after myself normally without causing extra pain 我可以正常自理，不會造成額外的疼痛	+0
☐ I can look after myself normally but it causes extra pain 我可以正常自理，但這會導致額外的疼痛	+1
☐ It is painful to look after myself and I am slow and careful 我照自理时很痛，但我会緩慢而小心	+2
☐ I need some help but can manage most of my personal care 我需要一些幫助，但大部分可以自理	+3
☐ I need help every day in most aspects of self-care 我每天在自理方面大多數都需要幫助	+4
☐ I do not get dressed, I wash with difficulty and stay in bed 我无法穿衣服，洗漱有困难，並保持卧床	+5

3. Lifting 提重

☐ I can lift heavy weights without extra pain 我可以提重物而不會感到額外的疼痛	+0
☐ I can lift heavy weights but it gives extra pain 我可以提重物，但會帶來額外的疼痛	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table 疼痛使我無法將重物從地板上抬起，但如果將它們放置在方便的放置，例如在桌子上，我就可以提起	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned 疼痛使我無法舉起重物，但如果位置方便，我可以提起輕到中等的重量	+3
☐ I can only lift very light weights 我只能提起很輕的重量	+4
☐ I cannot lift or carry anything 我根本無法提起或搬动任何東西	+5

4. Walking 步行

☐ Pain does not prevent me walking any distance 疼痛并不妨碍我走任何距離	+0
☐ Pain prevents me from walking more than 1 mile 疼痛使我無法步行超過 1 英里	+1
☐ Pain prevents me from walking more than ½ mile 疼痛使我無法步行超過0.5英里	+2
☐ Pain prevents me from walking more than 100 yards 疼痛使我無法步行超過 100 碼	+3
☐ I can only walk using a stick or crutches 我只能使用拐杖走路	+4
☐ I am in bed most of the time 我大部分時間都在卧床	+5

5. Sitting 坐著

☐ I can sit in any chair as long as I like 只要我願意我可以坐在任何的椅子上和想坐多久就坐多久	+0
☐ I can only sit in my favorite chair as long as I like 我只能坐在我最喜歡的椅子上，想坐多久就坐多久	+1
☐ Pain prevents me sitting more than 1hour 疼痛使我無法坐著超過 1 小時	+2
☐ Pain prevents me from sitting more than 30 minutes 疼痛使我無法坐着超過 30 分鐘	+3
☐ Pain prevents me from sitting more than 10 minutes 疼痛使我無法坐着超過 10 分鐘	+4
☐ Pain prevents me from sitting at all 疼痛讓我根本無法坐下	+5

6. Standing 站立

☐ I can stand as long as I want without extra pain 我可以想站多久就站多久，不會產生額外的疼痛	+0
☐ I can stand as long as I want but it gives me extra pain 我可以想站多久就站多久，但會給我帶來額外的痛苦	+1
☐ Pain prevents me standing for more than 1 hour 疼痛使我無法站立超過 1 小時	+2
☐ Pain prevents me from standing for more than 30 minutes 疼痛使我無法站立超過 30 分鐘	+3
☐ Pain prevents me from standing for more than 10 minutes 疼痛使我無法站立超過 10 分鐘	+4
☐ Pain prevents me from standing at all 疼痛讓我根本無法站立	+5

7. Sleeping 睡眠

☐ My sleep is never disturbed by pain 我的睡眠不被疼痛打擾	+0
☐ My sleep is occasionally disturbed by pain 我的睡眠偶爾會因疼痛而受到干擾	+1
☐ Because of pain I have less than 6 hours sleep 由於疼痛，我的睡眠時間不足 6 小時	+2
☐ Because of pain I have less than 4 hours sleep 由於疼痛，我的睡眠時間不足 4 小時	+3
☐ Because of pain I have less than 2 hours sleep 因為疼痛我的睡眠時間不足2小時	+4
☐ Pain prevents me from sleeping at all 疼痛讓我根本無法入睡	+5

8. Sex life (if applicable) 性生活（如果適用）

☐ My sex life is normal and causes no extra pain 我的性生活正常，沒有引起額外的疼痛	+0
☐ My sex life is normal but causes some extra pain 我的性生活正常，但會引起一些額外的疼痛	+1
☐ My sex life is nearly normal but is very painful 我的性生活幾乎正常，但非常痛苦	+2
☐ My sex life is severely restricted by pain 我的性生活受到疼痛的嚴重限制	+3
☐ My sex life is nearly absent because of pain 由於疼痛，我幾乎无法有性生活	+4
☐ Pain prevents any sex life at all 由於疼痛，根本無法進行任何性生活	+5

9. Social life 社交生活

☐ My social life is normal and gives me no extra pain 我可以正常社交，不会給我帶來額外的疼痛	+0
☐ My social life is normal but increases the degree of pain 我的社交生活正常，但会增加痛苦程度	+1
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, for example sport 疼痛除了限制了我喜欢的有活力的活动（比如運動）之外，沒有严重影我的社交生活	+2
☐ Pain has restricted my social life and I do not go out as often 疼痛限制了我的社交生活，我无法經常外出	+3
☐ Pain has restricted my social life to my home 疼痛將我的社交生活限制在家裡	+4
☐ I have no social life because of pain 由於疼痛我沒有社交生活	+5

10. Travelling 旅行

☐ I can travel anywhere without pain 我可以毫無疼痛地去任何地方	+0
☐ I can travel anywhere but it gives me extra pain 我可以去任何地方旅行，但会給我帶來額外的疼痛	+1
☐ Pain is bad but I manage journeys over two hours 疼痛很嚴重，但我可以堅持兩個多小時的旅程	+2
☐ Pain restricts me to journeys of less than 1 hour 疼痛限制我的行程不能超過 1 小時	+3
☐ Pain restricts me to short necessary journeys under 30 minutes 疼痛限制我出行，如有必要，只可以进行30 分鐘以內的短途旅行	+4
☐ Pain prevents me from traveling except to receive treatment 疼痛妨礙我出行，除了去接收治療	+5

Scoring Instructions:
Raw Score: Summation of Points
Raw Score: ______ Points

Percentage Score: $\dfrac{\text{Raw Score}}{\text{\# Completed Questions} * 5}$

Percentage Score: ______ %

Patient Insurance Information
病人保險資料

Please check any and all insurance coverage you or your spouse has applicable in this case.
請填寫任何及所有保險您或您的配偶適用於這種事例。

- o Auto accident 車禍意外
- o BCBS 藍十字藍盾
- o Major Medical 病醫療保險
- o Worker's Compensation 工人賠償金
- o Other 其它

Insurance Identification #
保險標識號碼:______________________________

Date of Accident
事故日期:______________________________

Insurance Name 保險名稱:______________________ Policy # 保單號碼:__________________

Address/Phone
地址 / 電話號碼______________________________

Adjuster 險損估計人:______________________ Claim# 索賠號碼:__________________

Medical and Legal Information
醫療和法律資料

Name of Attorney 律師姓名:______________________ Phone # 電話號碼:__________________

Address
地址:______________________________

Pregnant: _____Yes 是 懷孕: _____No 不是

Pacemaker: _____Yes 是 起搏器: _____No 不是

Family Physician and Phone Number
家庭醫生名字和電話: ______________________________

Patient Agreement
病人協議

Assignment and Release

I, the undersigned, have insurance coverage with ______________________ and assign directly to HealthTrac Family Wellness, Inc all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

分配和釋放

我，簽署人，在________________保險公司有保險范圍和，如果有的話，直接分配所有的醫療福利給 HealthTrac Family Wellness Inc，否則支付給我提供的服務。我明白我要負責所有的財務費用是否支付保險。本人批准醫生釋放所有必要信息來確保支付保險賠償。本人批准使用此簽名我所有的保險意見書。

____

Signature of Insured/Guardian
保險人 / 監護人簽名

Doctor's Lien

Medico Embargo

Claim#
*Numero De Reclamo:*___________________________

Date of Accident
*Fecha del accidente:*_______________________

Patient Name
*Nombre del Paciente:*___________________________

Insured Name
*Nombre del asegurado:*_____________________

Attorney
*Abogado:*___________________________

I hereby authorize and direct my attorney, insurance company or liability insurance adjustor to promptly pay Dr. Hui any monies due and owing him for medical fees incurred either from this accident or by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor.
Yo por este medio autorizo directamente a mi abogado, aseguranza, adjustador a pagarle prontamente al Dr. Hui cualquier dinero que provenga de mis gastos medicos ocasionados por el accidente or por cualquier razon por la que haya que pagar los recargos medicos retenidos como asentamiento, juicio o veredicto y lo que sea necesario para adecuadamente proteger el pago del doctor.

I fully understand that I am directly and fully responsible to Dr. Hui for all fees incurred in his office. This agreement is made solely for the doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees.
Yo completamente entiendo que solo yo directamente soy responsible de todos los gastos incurridos en la oficina del Dr. Hui. Este acuerdo se hace unicamente para adicional proteccion para el doctor.

I authorize Dr. Hui to furnish to any attorney, insurance company or adjustor with any and all medical and/or financial information as requested.
Yo autorizo a Dr. Hui a proporcionar, a la compania aseguradora o el ajustador con cualquier detalle medico o financiero que ellos requieran.

I agree that Dr. Hui be given Power of Attorney to endorse/sign my name on any and all checks for payment of my medical bill.
Yo acuerdo al Dr. Hui adarle el poder de fimar con mi nombre cualquier cheque para los pagos de los biles medicos.

I understand that this lien is effective for up to five years after my last office visit.
Yo entiendo que esta conexion es efectiva por mas de cinco anos despues de mi ultima visita.

A photocopy of this agreement shall be considered as effective and valid as the original.
Una fotocopia de este acuerdo es considerado tan efectivo y valido como la original.

Patient Signature
Firma: ____

Date
*Fecha:*_______________________

The undersigned being either the attorney or insurance company representative of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Dr. George Chi Hui, D.C.

Attorney's Signature: ____________________________________ Date: ______________________

HealthTrac Family Wellness
On Track to Great Health

4720 Peachtree Ind. Blvd., Suite 104 Norcross, GA 30071
Telephone: (678)740-9401 Fax: (770)670-6518

IRREVOCABLE ESCROW INSTRUCTION AND AGREEMENT

The undersigned patient (hereinafter "Patient") in order to induce HealthTrac Family Wellness (hereinafter the "Provider") to extend credit to the Patient, hereby irrevocable instruct my attorney and escrow agent, to pay to Provider the full amount of any bill for services rendered by the Provider, from the proceeds of my personal injury settlement or award within ten (10) days of receipt by him of same, excepting time for any negotiable instrument to clear.

The escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services from my accident.

____
Patient Signature

____

____

____
Patient Name and Address

Understood and agreed to by:

Dated:

____
HealthTrac Family Wellness

____
Provider Signature

Dated:

By: ____________________

Its: ____________________

HealthTrac Family Wellness

NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. **In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed.** However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so **at least 24 hours before your scheduled office appointment** to avoid paying a fee. In an effort to see patients promptly at the schedule time, this office does not double-book appointments; therefore, the 24 hour notification is necessary so that we may schedule other patients needing immediate appointments.

Missed office appointment fee is $50.00

**Fees are not covered by insurance and must be paid before you can reschedule your appointment.

我們的目標是滿足患者的需求，我們將盡一切努力有效地安排您的預約。同时，您也有責任盡一切努力保持預定的预約，並在约定的時間及時到達。但是，我們意識到，突发事件可能會妨碍您准时到达您的预约。出於對我們其他患者的公平和考慮，我們特此请求您，當您意識到無法准时到达預約時，應立即通知我們診所。

如果您需要取消或重新安排预約，則必須在预約时间的至少 24 小時前取消或重新安排预約，以免支付費用。為了及時在安排的時間看病人，本诊所不重複預約。因此，有必要提前 24 小時通知我们，以便我們安排其他有需要立即預約的患者。错过预约需支付費用如下：$50.00。

**費用不在保險包含範圍之内，必須在重新安排预約之前支付。

Nuestro objetivo es satisfacer las necesidades de nuestros pacientes y haremos todo lo posible para programar sus citas de manera eficiente. ***A cambio, es su responsabilidad hacer todo lo posible para cumplir con sus citas programada y llegar puntualmente a la hora indicada.*** *Sin embargo, nos damos cuenta de que los eventos imprevistos pueden impedir que cumpla con su cita. Para ser justos y considerados con nuestros otros pacientes, le solicitamos que notifique a nuestra oficina de inmediato cuando se dé cuenta de que no podrá asistir a su cita.*

Si necesita cancelar o reprogramar su cita, debe hacerlo ***al menos 24 horas antes de su cita programada para evitar pagar una tarifa.*** *En un esfuerzo por ver a los pacientes puntualmente a la hora programada, este consultorio no reserva citas dobles; por lo tanto, la notificación de 24 horas es necesaria para que podamos programar otros pacientes que necesiten citas inmediatas.*
La cuota para una cita perdida es: $ 50.00

** Las tarifas no están cubiertas por el seguro y deben pagarse antes de que pueda reprogramar su cita.

______________________________ _________________________

Patient Signature / 病人签名/ *Firma del paciente* Date / 日期/ *Fecha*

HealthTrac Family Wellness

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Si necesita cancelar o reprogramar su cita, debe hacerlo ***al menos 24 horas antes de su cita programada para evitar pagar una tarifa.*** *En un esfuerzo por ver a los pacientes puntualmente a la hora programada, este consultorio no reserva citas dobles; por lo tanto, la notificación de 24 horas es necesaria para que podamos programar otros pacientes que necesiten citas inmediatas.*
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Patient Signature / 病人签名/ *Firma del paciente* ______________________

Date / 日期/ *Fecha* ______________________