HealthTrac Family Wellness

Patient History Information

Please complete this form and then return to the receptionist. **- Please PRINT -**

请完整填写下列表格内容并将此表交还于我们的接待人员

- 请用正楷清晰填写 -

Date 日期: _____ Patient #:病例号: _____

Last Name 姓: _____ First and Middle Name 名: _____ Height: 身高: ____ ' ____ "

Age 年龄: _____ Date of Birth 出生年月: _____ ❑ Male 男 ❑ Female 女 Weight: 体重: _____ lb.

Is your visit to our clinic today for care resulting from an auto accident or workers compensation injury?
您今天来此门诊的原因是由于遭受车祸伤害或是由于工作受伤吗? ❑ Yes 是 ❑No 否

Are you currently in litigation due to any health related problems?
您近期是否因为健康问题而处于诉讼过程中? ❑ Yes 是 ❑No 否

If your answer to either of the questions above is "Yes", please see the receptionist before continuing.
如果您在以上问题中有任意一个回答为"是"，在您继续填写之前，请告知我们的接待人员。

Home Address 家庭住址: _____

City 城市: _____ State 省（市）: ____ Zip Code 邮编: _____

Telephone 电话: Home 家庭: _____ Work 工作电话: _____ Mobile 移动电话: _____

Social Security # 社会安全号码: _____ Email 电子邮件: _____

Occupation 职业: _____ Employer 公司名称: _____

❑ Full-Time Job 全职工作 ❑Part-Time Job 兼职工作 ❑ Multiple Jobs 多种工作 ❑Self- Employed 自雇 ❑ Retire 退休 ❑ Suspended 暂停工作 ❑Unemployed 失业

Work Address 工作地址: _____

Marital Status 婚姻状况: ❑ Single 单身 ❑ Married 已婚 ❑ Divorced 离异 ❑ Widowed 丧

Spouse's Name 配偶姓名: _____ Number of Children 几个子女: _____ Ages 年龄: _____

Phone Number 电话: _____

Emergency Contact Person 紧急联系人: _____ Phone Number 电话: _____

Have you received chiropractic care in the past? 你之前接受过脊骨神经矫正治疗吗? ❑ Yes 是 ❑ No 否 When? 于何时? _____

If yes, please give name of the Chiropractor:
如果是，请提供脊骨神经矫正医师姓名: _____

Please describe the reason for previous care:
请描述之前接受矫正的原因: _____

Name of your Medical Doctor
西医的名字: _____

List the name of your health insurance company:
健康保险公司的名字: _____

Policy number is:
保险单号码是: _____

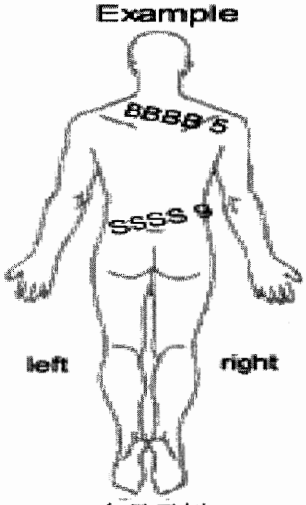
Patient Name:_____ Date:_____ File:_____

Reason(s) for seeking chiropractic care starting with the most severe:
列举需要脊骨神经矫正治疗的原因，请从最严重的问题开始：

	Chief Complaint 健康问题及相关	Approximate Date Started 大概开始日期
1.	_____	_____
2.	_____	_____
3.	_____	_____

Areas of injury or discomfort:
损伤区域/不适区域:

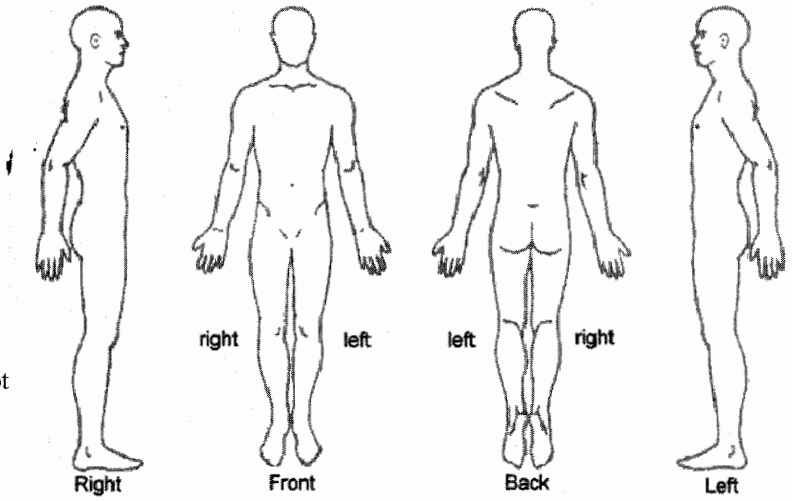
On the following chart please mark area(s) of injury or discomfort (see example). Mark all areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).
请在下列图表中标明您的损伤区域或者不适区域（参见示例） 并在所有表示区域中标明相应痛感与等级 1（略微不适）到 10（极度疼痛）



参见示例

NNNN	Numbness 麻木
PPPP	Pins & Needles 针刺感疼痛
BBBB	Burning 灼热感
AAAA	Aching 酸、胀痛
SSSS	Stabbing 刺痛

Circle any area of pain not represented by a symbol.
请在右图圈出疼痛区域，并标痛感和程度（1-10）



右侧 右 正面 左 左 背面 右 左侧

Please indicate any medications you are currently taking:
请提供近期任何相关用药史：

- ❑ Blood pressure 高血压
- ❑ Muscle relaxants 肌肉松弛剂
- ❑ Stimulants 神经药物
- ❑ Blood thinners 血液稀释剂
- ❑ Steroids 类固醇
- ❑ Birth control pills 避孕药
- ❑ Stimulants 兴奋剂
- ❑ Pain killers (including Aspirin) 止痛剂（包括阿司匹林）
- ❑ Insulin 胰岛素
- ❑ Antibiotics 抗生素
- ❑ Sleeping Pills 安眠药

❑ Others 其它：_____

Name of nutritional supplements and/or dietary aids:
营养/膳食补充剂名称: _____

Patient Name:_____ Date:_____ File:_____

Review of Systems, Please check any condition you have had in the past or have now:
系统评价 若你过去或者现在有以下状况，请在方框内打勾：

Now 现在	Past 过去		Now 现在	Past 过去		Now 现在	Past 过去	
❑	❑	Back Pain 背部疼痛	❑	❑	Chest Pain 胸部疼痛	❑	❑	Difficulty Urinating 泌尿困难
❑	❑	Neck Pain 颈部疼痛	❑	❑	Poor Circulation 循环不畅	❑	❑	High BP 高血压
❑	❑	Shoulder/Arm Pain 肩/手臂疼痛	❑	❑	Skin Problems 皮肤问题	❑	❑	Arrhymia 心律不齐
❑	❑	Hip/Leg Pain 髋部/腿部疼痛	❑	❑	Colon Trouble 肠道	❑	❑	Frequent Infections 经常感染
❑	❑	Sciatica 坐骨神经痛	❑	❑	Stomach Trouble 胃	❑	❑	Difficulty Breathing 呼吸困难
❑	❑	Arthritis 关节炎	❑	❑	Kidney Problems 肾脏	❑	❑	Liver Trouble 肝脏
❑	❑	Asthma 哮喘	❑	❑	Easy Bruising 易青肿	❑	❑	Pregnancy 女性：怀孕
❑	❑	Prostate Problems 男性：前列腺				❑	❑	Menstrual Problems 月经问题
❑	❑	None of the above 无以上症状	❑	❑	None of the above 无以上症状	❑	❑	None of the Above 无以上症状

Have you ever: 你是否曾经 ***Comments: 评价:***

Had any accidents, falls, traumas, or injuries:
遭受过意外事故、跌伤、损伤或伤害: ❑Yes 是 ❑ No 否 _____
Been hospitalized 入院治疗: ❑ Yes 是 ❑ No 否 _____
Had a broken bone 骨折历史: ❑ Yes 是 ❑ No 否 _____
Had surgery 外科手术: ❑ Yes 是 ❑ No 否 _____
Been treated for an emotional disorder
因为情绪障碍接受治疗: ❑ Yes 是 ❑ No 否 _____
Been bedridden for more than a week
卧床一周以上: ❑ Yes 是 ❑ No 否 _____

Health/Risk Factors:健康/危险因素: ***Comments:评价:***

Do you smoke? 您吸烟吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ Light ❑ Medium ❑ Heavy
Do you drink alcohol? 您喝酒吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Once/Week ❑ 2-5 Times/Week ❑ Daily
Do you have a healthy diet?
您的饮食合理吗？ ❑ Yes 是 ❑ No 否 _____
Do you exercise regularly?
您经常锻炼吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ 3-5 Times/Week ❑ Daily
Do you sleep well? 你的睡眠好吗？ ❑ Yes 是 ❑ No 否 _____
Is your job stressful?
您的工作压力大吗？ ❑ Yes 是 ❑ No 否 _____
Do you drink caffeine? 你喝咖啡或茶吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ Daily
What is your dominate hand?
你是用哪个手写字？ ❑ Right 右手 ❑ Left 左手 ❑ Both 两个手都可以
Can you think of any other habit or activity that has a positive or negative effect on your health?
您还能想到一些对您的健康有益或者有害的生活习惯吗？ ❑ Yes 是 ❑ No 否 _____

Patient Name:_____ Date:_____ File:_____

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 / 姓名（写正楷） Signature / 签名 Date / 日期

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

病人签名 日期 — 姓名（用正楷写名字）

_____

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.

病人/代表人
签　　名: _____
Signature of Patient or Personal Representative

姓　名
（写正楷）: _____.
Printed Name of Patient

Date of Signing
日期: _____.

Description of Personal Representative's Authority

Patient Name:_____ Date:_____ File:_____

Personal Injury Consultation Form
人身傷害諮詢表

Name
姓名:_____ Date
日期:_____

Date of Accident
事故日期: _____

1. At impact did you experience a flash in your head? _____Yes 有
   碰撞的一刻您有否經驗到一度閃光在您腦袋裡？ _____No 沒有
   Did you lose consciousness? _____Yes 有
   您有沒有昏迷？ _____No 沒有
2. Immediately following the accident how did you feel?
   事故發生後當時感覺怎麼樣？
   _____
   Did you become? (Please circle)
   您當時有沒有感覺到？〔請圈〕
   Confused 困惑，Disoriented 迷失方向，Light headed 頭暈眼花，Nauseated 想吐，
   Blurred vision 視力模糊，Ringing/Buzzing in ears 鈴聲 / 嗡嗡聲在耳邊
3. Are you currently experiencing? (Please circle)
   您目前有沒有經驗到？〔請圈〕
   Restlessness 煩躁不安，Irritable 易怒，Difficulty concentrating and remembering
   困難集中精神和記憶，Sleeplessness 失眠，Forgetfulness 健忘，Reduced
   tolerance to heat or cold 降低耐熱或冷
4. Over the next few hours and days, what symptoms did you feel?
   接下來的幾個小時或幾天，您感覺到什麼症狀？
   _____
   _____
   _____
5. Please tell us how your accident happened.
   請告诉我们您的事故是怎么发生的：
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
6. Any other symptoms to report? 還有其它症狀嗎？
   _____
7. Was your car moving at impact? How fast?
   碰撞時您的車在移動嗎？ _____Yes 是 _____No 不是 速度有多快？ _____
8. Was the other car moving? How fast?
   另外一部車也在移動嗎？ _____Yes 是 _____No 不是 速度有多快？ _____
9. Which way was your body facing at impact? Straight Right Left
   碰撞時您的身體是面對哪個方向的？ ___ 直面 ____右面 ____左面
10. Which way was your head facing at impact? Straight Right Left
    碰撞時您的頭部是面對哪個方向的？ ___ 直面 ____右面 ____左面
11. Were you surprised by the impact?
    碰撞有沒有令您驚訝？ _____Yes 有 _____No 沒有
12. Does your car have a headrest?
    您的車有沒有頭靠？ _____Yes 有 _____No 沒有

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。

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

Patient Name:_____ Date:_____ File:_____

Doctor's Lien
醫生的留置權

Claim#
理賠號碼:_____
Patient Name
病人姓名:_____
Attorney
律師姓名:_____

Date of Accident
意外發生日期:_____
Insured Name
保險人姓名:_____

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.
我特此批准和指導我的律師，保險公司或責任保險調節人，及時支付任何應付款項許醫生和他因醫療產生之費用無論是從這次事故或因其它任何法案，為了必要充分保護和充分補償許醫生。

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.
我完全明白我是要直接負責支付所有在許醫生的診所的治療。此協議的目的僅僅是為了醫生的額外保護。

I authorize Dr. Hui to furnish to any attorney, insurance company or adjustor with any and all medical and/or financial information as requested.
我批准許醫生提供任何律師，保險公司或調節人任何或所有的醫療和 / 或財務信息的要求。

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.
我同意給許醫生委託書在任何和所有支票支付我的醫療費用上認可 / 註冊我的名字。

I understand that this lien is effective for up to five years after my last office visit.
我明白這留置權的有效期是直致為最後一次治療的 5 年後才結束。

A photocopy of this agreement shall be considered as effective and valid as the original.
這協議的影印本能被視為和原版一樣有效。

Patient Signature
病人簽名: _____

Date
日期:_____

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

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预約。**同时，您也有責任盡一切努力保持預定的預約，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內，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

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预約。同时，您也有責任盡一切努力保持預定的預約，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约，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。

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