

Hunt for Wellness

Nutrition · Chiropractic · Weight Loss

9422 S. Tryon Street

Charlotte, NC 28273

Phone: (704) 588-1792 Fax: (704) 588-2718

PERSONAL INFORMATION:

Date/ Fecha: ___/___/___ Social Security #: ___-___-___

First name/ Nombre: _____

Middle/ Segundo: _____

Last name/ Apellido: _____

Nickname/ Apodo: _____

Male/ Masculino

Female/ Femenino

Address/ Dirección: _____

City/ Ciudad: _____ State/ Estado: _____ ZIP: _____

Birthday/ Cumpleaños: ___/___/___ Age/ Edad: _____

Home Phone# / Telefono de casa: _____

Work Phone# / Telefono de trabajo: _____

Other Phone# / Otro Numero: _____

E-Mail: _____

Reffered by/ Referido por: _____

Employer/ Empleador: _____

Address/ Dirección: _____

City/ Ciudad: _____ State/ Estado: _____ ZIP: _____

Occupation/ Ocupacion: _____

Status/ Estatus: Married/ Casado Single/ Soltero

Divorced/ Divorciado Separated/ Separado

Widowed/ Viudo

Do you have any Children? / Tiene Hijos? Yes/ Si No

How many? / Cuantos?: _____

PRIMARY INSURANCE/SEGURO PRIMARIA:

Co. Name/ Compañía: _____

Address/ Dirección: _____

City/ Ciudad: _____ State/ Estado: _____ ZIP: _____

Phone# / Telefono: _____

Insured Name/ Asegurado: _____

Relation/ Relación: _____

Address/ Dirección: _____

City/ Ciudad: _____ State/ Estado: _____ ZIP: _____

ID Number: _____

Group # / Numero de grupo: _____

Date of Birth/ Fecha de nacimiento: ___/___/___

Insured Employer/ Empleador: _____

ACCOUNT INFO/INFORMACION DE CUENTA

Person in charge of any balances left on account:

Name/ Nombre: _____

Address/ Dirección: _____

City/ Ciudad: _____ State/ Estado: _____ ZIP: _____

Relation/ Relación: _____

Social Security #: _____

Driver License # / # de Licencia: _____

Work Phone# / Telefono de trabajo: _____

_____(initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand i am solely responsible for any balance not paid by my insurance company.

IN CASE OF EMERGENCY/EMERGENCIA

Whom should we contact/ Persona de contacto: _____

Home Phone# / Telefono de casa: _____

Work Phone# / Telefono de trabajo: _____

Other Phone# / Otro Numero: _____

Relation/ Relación: _____

Medical Doctor/ Doctor medico: _____

Doctor's # / # de doctor Medico: _____

Hunt for Wellness

9422 S. Tryon St. Charlotte, NC 28273

Phone: (704) 588-1792 Fax: (704) 588-2718

Dr. Tunis C. Hunt Sr. Dr. Estela de Arcos Hunt Dr. Tunis C. Hunt Jr.

Reason for today's visit: Emergency New Injury Old Injury Chronic pain Wellness

Are you in pain: Yes No Rate your pain with the following scale: discomfort _____ intense _____
 1 2 3 4 5 6 7 8 9 10

Did your injury occur during: Work Sports/Play Auto Accident Routine/ Household Activity

When did your condition/accident occur? ____/____/____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?
 Yes No

Explain: _____

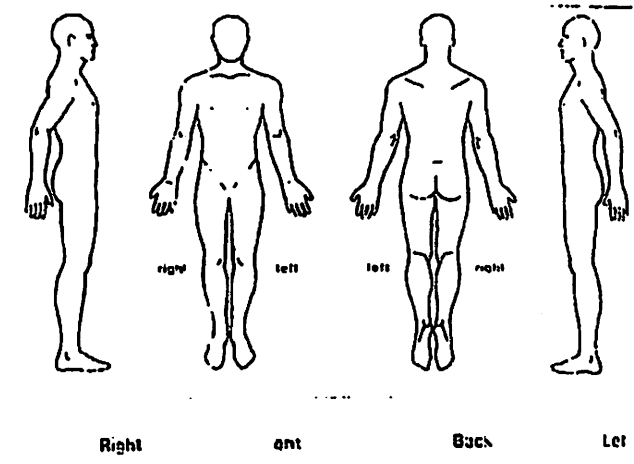
Using the adjacent body charts, please circle
 All affected areas.

Have you been treated by a Medical Physician for this condition?
 Yes No If so, where? _____

Have you ever been treated by a Chiropractor? Yes No

Clinic or Dr's name: _____

Clinic phone#: _____



Are you taking any of the following medications? Nerve Pills Pain Killers (including aspirin) Muscle relaxers
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murrur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/ Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS/ ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia/ Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe/ Frequent Headaches	Y N Kidney Problems
Y N Ulcers/ Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ____/____/____

For woman: Are you taking Birth Control? Yes No Are you Pregnant? No Yes If so, how many weeks? _____

Hunt for Wellness

Total Health. New Approach.

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale			
0 = Never had the symptom	2 = Occasionally have it, severe effect	4 = Frequently have it, severe effect	
1 = Occasionally have it, mild effect	3 = frequently have it, mild effect		

Column # 1

	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°F)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound

	Indecisiveness
	Feeling of being overwhelm or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floater, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)

Column # 2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep

	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness, or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)

Neurotoxic Questionnaire

	Total Columns 1 & 2
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Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- ⓐ The pain comes and goes and is very severe.
- ⓑ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- ⓐ Because of pain my normal sleep is reduced by less than 75%.
- ⓑ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- ⓐ Pain prevents me from sitting more than 10 minutes.
- ⓑ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- ⓐ I cannot stand for longer than 10 minutes without increasing pain.
- ⓑ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- ⓐ I cannot walk more than 1/4 mile without increasing pain.
- ⓑ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⓐ Because of the pain I am unable to do some washing and dressing without help.
- ⓑ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⓐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⓑ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⓐ Pain restricts all forms of travel except that done while lying down.
- ⓑ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- ⓐ Pain has restricted my social life to my home.
- ⓑ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- ⓐ My pain is gradually worsening.
- ⓑ My pain is rapidly worsening.

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Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ I have no pain at the moment.
- Ⓛ The pain is very mild at the moment.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is fairly severe at the moment.
- Ⓩ The pain is very severe at the moment.
- Ⓟ The pain is the worst imaginable at the moment.

Sleeping

- Ⓐ I have no trouble sleeping.
- Ⓛ My sleep is slightly disturbed (less than 1 hour sleepless).
- Ⓜ My sleep is mildly disturbed (1-2 hours sleepless).
- Ⓨ My sleep is moderately disturbed (2-3 hours sleepless).
- Ⓩ My sleep is greatly disturbed (3-5 hours sleepless).
- Ⓟ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓐ I can read as much as I want with no neck pain.
- Ⓛ I can read as much as I want with slight neck pain.
- Ⓜ I can read as much as I want with moderate neck pain.
- Ⓨ I cannot read as much as I want because of moderate neck pain.
- Ⓩ I can hardly read at all because of severe neck pain.
- Ⓟ I cannot read at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓜ I have a fair degree of difficulty concentrating when I want.
- Ⓨ I have a lot of difficulty concentrating when I want.
- Ⓩ I have a great deal of difficulty concentrating when I want.
- Ⓟ I cannot concentrate at all.

Work

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓜ I can only do most of my usual work but no more.
- Ⓨ I cannot do my usual work.
- Ⓩ I can hardly do any work at all.
- Ⓟ I cannot do any work at all.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- Ⓛ I can look after myself normally but it causes extra pain.
- Ⓜ It is painful to look after myself and I am slow and careful.
- Ⓨ I need some help but I manage most of my personal care.
- Ⓩ I need help every day in most aspects of self care.
- Ⓟ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓩ I can only lift very light weights.
- Ⓟ I cannot lift or carry anything at all.

Driving

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓜ I can drive my car as long as I want with moderate neck pain.
- Ⓨ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓩ I can hardly drive at all because of severe neck pain.
- Ⓟ I cannot drive my car at all because of neck pain.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓜ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓨ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓩ I can hardly do any recreation activities because of neck pain.
- Ⓟ I cannot do any recreation activities at all.

Headaches

- Ⓐ I have no headaches at all.
- Ⓛ I have slight headaches which come infrequently.
- Ⓜ I have moderate headaches which come infrequently.
- Ⓨ I have moderate headaches which come frequently.
- Ⓩ I have severe headaches which come frequently.
- Ⓟ I have headaches almost all the time.

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Phone: (704) 588-1792 Fax: (704) 588-2718

Dr. Tunis C. Hunt Sr. Dr. Estela de Arcos Hunt Dr. Tunis C. Hunt Jr.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I _____ understand that as part of my health care, Hunt for Wellness, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serve as:

- A basic for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means of information for applying my diagnoses and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health professionals

I understand and have been provided with a notice of Information Practices that provides a more complete description of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to have my health information maybe used or disclosed to carry out treatment, payment, or health care operations

I understand that Hunt for Wellness is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that refusing to sign this consent or revoking the consent, to this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Hunt for Wellness reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should Hunt for Wellness change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree Email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept/decline the terms of this consent.

Patient Signature: _____

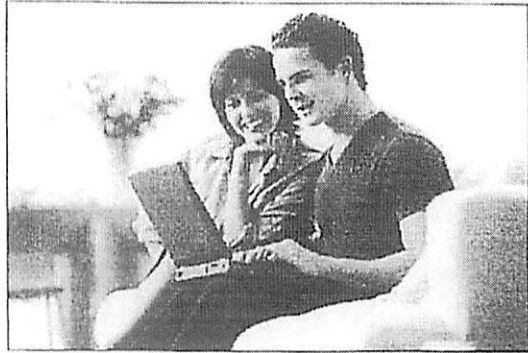
Date: ____/____/____

WELLS FARGO BANK

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:



First name: _____

Last name: _____

Date of birth: ____ / ____ / ____

Email address: _____

Please check the health subjects that most interest you:

- | | |
|---|--|
| <input type="checkbox"/> Headaches and Neck Pain | <input type="checkbox"/> Diet and Nutrition |
| <input type="checkbox"/> Backaches and Sciatica | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Children's Health Issues | <input type="checkbox"/> Wellness Topics |
| <input type="checkbox"/> Exercise and Fitness | <input type="checkbox"/> Women's Health Issues |

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.