

# 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: \_\_\_\_\_

Referred 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?: \_\_\_\_\_

## PERSONAL INJURY ONLY:

Date of Accident/ Fecha de Accidente: \_\_\_/\_\_\_/\_\_\_

Accident State Occured/ Estado donde Accidente ocurrio: \_\_\_\_\_

Ins. Co. Name/ Comp. de aseguransa: \_\_\_\_\_

Phone# / Telefono : \_\_\_\_\_

FAX # / # de Fax : \_\_\_\_\_

Claim # / # de reclamo : \_\_\_\_\_

Adjustor's Name/ Nombre de adjuster : \_\_\_\_\_

## PRIMARY INSURANCE/ SEGURO PRIMARIA:

Co. Name/ Compañía: \_\_\_\_\_

Address/ Dirección: \_\_\_\_\_

City/ Ciudad: \_\_\_\_\_ State/ Estado: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone# / Telefono: \_\_\_\_\_

Insured SS# / SS# de Asegurador: \_\_\_\_\_

Group # / Numero de grupo: \_\_\_\_\_

Insured Name/ Asegurado: \_\_\_\_\_

Relation/ Relación: \_\_\_\_\_

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

NORTH CAROLINA CHIROPRACTIC ASSOCIATION

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: \_\_\_\_\_

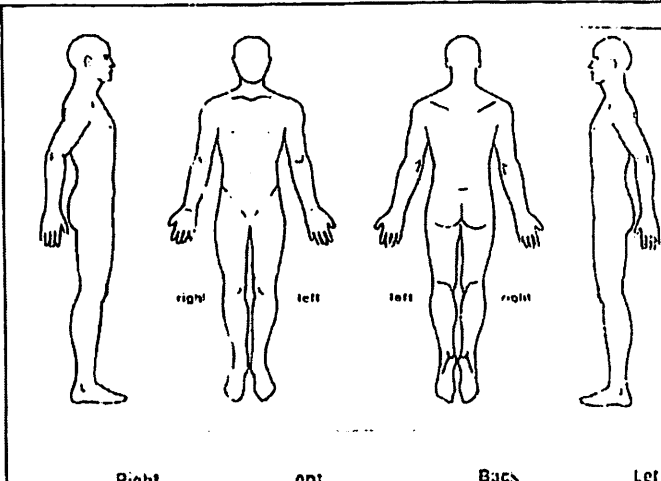
Using the adjacent body charts, please circle  
 All affected areas.

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 Murmur	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/Siezuers/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? \_\_\_\_\_

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

## Assignment of Benefits

IN CONSIDERATION of the willingness of Hunt for Wellness to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Hunt for Wellness any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on \_\_\_\_\_ to the extent of the chiropractic services rendered. I make this agreement with out prejudice to any rights I may have to prosecute legal claims against any party who maybe liable for my injuries, but I hereby authorize and instruct you to pay directly to Hunt for Wellness, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Hunt for Wellness for its services rendered.

I appoint Hunt for Wellness as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Hunt for Wellness

I authorize Hunt for Wellness to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that i remain personally liable for the total amount due to Hunt for Wellness for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Hunt for Wellness is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Hunt for Wellness for its costs of recovery, including reasonable attorney's fees.

## NOTICE OF LIEN:

Pursuant to N.C.G.S. 44-49 and 44-50, Hunt for Wellness hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the named patient in compensation for settlement of injuries sustained, whether in litigation or otherwise

Hunt for Wellness hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Hunt for Wellness agrees to be bound by any confidentiality agreements regarding the contents of the accounting

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## **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: \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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.

Back  
Index  
Score

# 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.

## **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.

## **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).

## **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.

## **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.

## **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.

## **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.

## **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.

## **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.

## **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.

Neck  
Index  
Score

## Website Membership Enrollment

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.

Lifecycle:  
Chiropractor