ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code** _____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION.

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

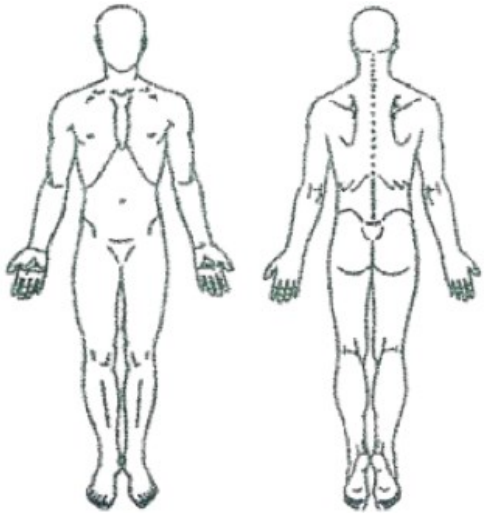
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None ***Unbearable***

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the injury? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Do you have any medication allergies?	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH

Do you have pain or lump in scrotum or testicles?
☐ Yes ☐ No

Do you have an impaired libido (sex drive)?
☐ Yes ☐ No

Do you have discharge from your penis?
☐ Yes ☐ No

Do you have prostate issues?
☐ Yes ☐ No

When was your last prostate exam?
☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a prostate exam
☐ Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test?
☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a PSA blood test
☐ Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test?
☐ Normal or low ☐ Moderate
☐ High ☐ Never had a PSA level done
☐ Prefers not to answer or don't know

WOMEN'S HEALTH

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take hormone replacement therapy (HRT)?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.
INFORMED CONSENT

Dear Patient,
Every type of heath care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called "informed consent".

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the brain stem. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA Vol. 37 No. 2, June 2, 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes disc hernations in both the neck and the back. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely, that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move the bones and ligaments limit the amount of joint movement. Rarely will chiropractic adjustments, traction, massage therapy, etc., tear some muscle or ligament fibers. If this does occur the result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fracture: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely will chiropractic adjustments "crack" or fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. If a burn occurs the result is a temporary increase in skin pain. In extreme cases, some blistering of the skin may occur. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic

treatment, other than those noted above. These other problems or complications occur so rarely that it is impossible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

FINANCIAL POLICY

We respectfully ask that you read and understand our financial policies as they apply to your particular situation.

Patients Without Insurance: We will gladly discuss our discounted time of service pricing. We require payment when services are provided at each visit unless other arrangements have been pre-arranged and agreed upon.

Group or Individual Insurance: When possible, we will call to verify your insurance benefits; however, the coverage quoted to us by your insurance carrier is not a guarantee of payment. Your insurance coverage is an agreement between you and the insurance carrier, not between our clinic and the carrier.
• Co-pays are due at the time of service.
• Co-payments, deductibles and co-insurance are your responsibility per the terms of your insurance contract.
• The clinic is restricted to a "timely filing period" by insurance carriers. You must supply the clinic with your insurance card in a timely fashion, so the claim may be submitted and paid. Any unpaid claim due to insurance information not being supplied in a timely manner will be your responsibility to pay in full.

"On the Job" Injury (Worker's Compensation): If you are injured on the job, inform your employer of the accident and obtain the name and address of the company's insurance carrier. If your employer does not provide us with this information or if you suspend or terminate care, any fees for services rendered are your financial responsibility.

Personal Injury or Automobile Accidents: Please notify your auto insurance carrier of your visit to our office immediately. Also, notify our insurance specialist if an attorney is representing you. You are ultimately responsible for your bill. Once the claim is settled payment is due immediately. If you suspend or terminate care, any fees for services rendered are your responsibility. If payment isn't complete in one lump sum, a monthly payment plan will be expected until the balance is paid in full.

Medicare: We do accept assignment from Medicare. Medicare ONLY covers manual manipulation (adjustment) of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%, as well as any non-covered services.

Medicaid or Forward Health: We do accept Forward Health. Co-pays may apply and are due at time of service.

Returned Checks: A $30 charge will be added to the account balance to cover the financial institution's returned check fee.

Collections: If an account is not paid within a reasonable time after numerous ignored billing statements, the account will be sent to collections. A charge of 35% will be added to the balance owed, in addition to attorney and/or small claims court fees.

Assignment of Benefits: I hereby authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise by payable to me under any insurance, pre-paid health care plan or Medicare be made directly to the clinic.

I understand that I am personally responsible for payment of any and all services rendered,

covered or non-covered by insurance. I am also responsible for updating my health insurance information with the clinic any time the information changes, terminates, or new coverage begins.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

• We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
• We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
• We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / _____