HIGLEY
FAMILY CHIROPRACTIC
Discover the Difference

Patient Information Sheet

PATIENT:

First Name:______________________________ Last Name:________________________________ Middle:______________

I Prefer To Be Addressed As:_____________________________________ Status: Single / Married / Widowed / Divorced

Gender: M F Date of Birth: ____ /____ /____ Age:______ Email address: _________________________________

Mailing Address:___________________________________ Apt #____________ Number of Children:__________________

City:________________________ State:_______________ Zip Code:__________ Referred by:_____________________

Home Phone #:____________________________________ Work Phone #:____________________________________

Employer Name:____ Occupation:__________________________________

Employer Address:____

City:____ State:______________ Zip Code:_________________________

SPOUSE or GUARDIAN:

First Name:______________________________ Last Name:________________________________ Middle:______________

Employer Name:____ Work Phone #:________________________________

Date of Birth: ____ /____ /____

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name of Person Responsible For This Account:____

Relation to Patient:____________________ Email address:____

Home Address:____ Apt #__________________________________

City:____ State:______________ Zip Code:_________________________

Home Phone #:____________________________________ Work Phone:_______________________________________

Employer Name:____ Occupation:__________________________________

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I Request Services X____ Date:__________________________________

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Patient Name____

Describe Major Complaints and Symptoms____
____
____

Date You First Noticed Symptoms_________________ How Was The Condition Caused_______________

Has This Condition Happened Before _______When__________________ Name of Doctor_____________

Diagnosis______________________ Length of Time Under Care_______________ Results____________

Have You Ever Been In An Accident__________ Auto, Work, Home, Leisure, Other__________________

Describe Including Date(s) ____

Describe Fractures (Past or Present) ____

Describe Any Type Of Surgery ____

Describe The Medication You Are Taking For Any Condition_____________________________________

The Past Have You Taken Medication On A Regular Basis __________ Date Of Last Medical Exam______

Date Of Last Chiropractic Exam____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

___Anemia
___Appendicitis
___Arteriosclerosis
___Asthma
___Cancer
___Chicken Pox
___Cold Sores
___Diabetes
___Diphtheria
___Eczema
___Emphysema
___Epilepsy
___Goiter
___Heart Disease
___Hypoglycemia
___Measles
___Multiple Sclerosis
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic Fever
___Scarlet Fever
___Stroke
___ Tonsillitis
___Tuberculosis
___Typhoid Fever
___Whooping Cough
___Other:
____
____
____

Your signature below will verify that all the information you have given us is accurate and that you have answered the health report questions entirely.

Signature____Date_______________________________

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PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD IN THE PAST

NOW PAST

GENERAL

- __ __ Allergy
- __ __ Chills
- __ __ Convulsions
- __ __ Depression
- __ __ Dizziness
- __ __ Fainting
- __ __ Headache
- __ __ Loss of Sleep
- __ __ Loss of Weight
- __ __ Nervousness
- __ __ Tremors

MUSCLE & JOINT

- __ __ Arthritis
- __ __ Bursitis
- __ __ Hernia
- __ __ Low back pain
- __ __ Neck Pain or Stiffness
- __ __ Pain Between Shoulders

Pain or Numbness in:

- __ __ Shoulders
- __ __ Arms
- __ __ Elbows
- __ __ Hands
- __ __ Hips
- __ __ Legs
- __ __ Knees
- __ __ Feet
- __ __ Painful Tailbone
- __ __ Sciatica
- __ __ Swollen Joints

NOW PAST

GASTRO-INTESTINAL

- __ __ Colon Trouble
- __ __ Constipation
- __ __ Diarrhea
- __ __ Difficult Digestion
- __ __ Gall Bladder Trouble
- __ __ Hemorrhoids
- __ __ Jaundice
- __ __ Liver Trouble
- __ __ Pain over Stomach
- __ __ Ulcers

E.E.N.T.

- __ __ Crossed Eyes
- __ __ Deafness
- __ __ Earache
- __ __ Enlarged Glands
- __ __ Eye Flashes
- __ __ Eye Pain
- __ __ Hay fever
- __ __ Hoarseness
- __ __ Nasal Obstruction
- __ __ Sinus Infection
- __ __ Sore Throat

CARDIOVASCULAR

- __ __ Hardening Arteries
- __ __ High Blood Pressure
- __ __ Low Blood Pressure
- __ __ Pain Over Heart
- __ __ Cold Hands or Feet
- __ __ Slow Beating Heart
- __ __ Rapid Heart Beat
- __ __ Swelling Ankles

NOW PAST

RESPIRATORY

- __ __ Chest Pain
- __ __ Chronic Cough
- __ __ Difficult Breathing
- __ __ Wheezing

GENITO-URINARY

- __ __ Bed Wetting
- __ __ Blood in Urine
- __ __ Frequent Urination
- __ __ Can't Control Urine
- __ __ Painful Urination
- __ __ Prostate Trouble
- __ __ Pus in Urine

FOR WOMEN ONLY

- __ __ Cramps or Backache
- __ __ Excessive Flow
- __ __ Hot Flashes
- __ __ Irregular Cycle
- __ __ Lumps in Breast
- __ __ Menopausal Symptoms
- __ __ Painful Menses
- __ __ Vaginal Discharge
- __ __ Miscarriage

Are You Pregnant
YES _____ NO ______

Do not write below this area, for office use only.

Symptoms:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Other Notes:

____
____

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TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. 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.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.
HEALTH: A state of optimal physical, mental and social wellbeing, not merely the absence of disease or infirmity.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnosis or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________ have read and understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic care on this basis.

____ ______________________
(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 terms of acceptance 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 period: ______________________

____
(signature) ***(date)***

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PRIVACY CONSENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

I, ______________________, hereby state that by signing this consent, I acknowledge and agree as follows:

- Higley Family Chiropractic will take every means necessary to protect my PHI. This means that they will not engage in any electronic transaction, such as fax and email, with others regarding my health care information.

- Higley Family Chiropractic has the right to transfer any health records, via US mail, if a written request is made by the patient.

- Higley Family Chiropractic may use and or disclose my PHI (which may include information about my health condition and the treatment provided to me) in order to treat me and obtain payment for that treatment and as necessary for the practice to conduct its specific health care operations.

- I understand that, and consent to, the following appointment reminders that may be used by Higley Family Chiropractic: a postcard mailed to me at the address which I have provided; or by telephoning my home and leaving a message on an answering machine or with an individual answering the telephone.

- I understand that I have the right to request that Higley Family Chiropractic restrict how my PHI I used and/ or disclosed to carry out treatment, payment or healthcare operations. However the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the practice.

- I understand that if I do not sign this consent or if I revoke it at any time, Higley Family Chiropractic has the right to refuse to treat me.

- I understand and consent to the following other types of correspondence from this office:
  · Periodic mailings of general health information in the form of a newsletter.
  · Letters or bill mailed in an envelope with Higley Family Chiropractic on the return address.

- I understand and consent to Higley Family Chiropractic using my picture in a balloon on their wall. (Applies to children only)

- I understand and consent to Higley Family Chiropractic using my Chiropractic story as a testimonial in their testimonial books that are used in the office. (Separate signature is also required for this)

I have read and understand the above notice and all of my questions have been answered to my full satisfaction in a way that I understand.

______________________________ ______________________
Signature Date