CLEAR FORM

Black & Gold
CHIROPRACTIC & WELLNESS

Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Date: _____ Social Security #_____ - _____ - _____

Name: _____ _____ _____
Last First M.I

Permanent Address_____ City_____ State____ ZIP_____

E-mail (Doctors will communicate with you via email) _____

Cell Phone: (_____) - _____ - _____ Home Phone: (_____) - _____ - _____

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____ App. Reminders?

Sex: ___Male ___Female ___Decline to Answer Age: _____ Birthdate: _____

___Married ___Separated ___Widowed ___Divorced ___Single ___Partnered for ___Yrs ___Minor

Preferred Language: _____ Ethnicity: Hispanic or Latino___ Not Hispanic or Latino___ Decline___

Race (Circle): American Indian or Alaska Native___ Asian___ Black or African American___ White (Caucasian)___
Native Hawaiian or Pacific Islander___ Other (specify)_____ I Decline to Answer___

Patient Employer/School _____

Address: _____ City_____ State____ ZIP_____

Phone: (_____) - _____ - _____ Occupation: _____

Spouse's Name: _____ SS#____ - ____ - _____ Phone: (____) - _____ - _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone_____

ACCIDENT INFORMATION: Is condition due to an accident? Yes___ No___ Date of Accident _____
Type of Accident: Auto___ Work___ Home___ Other___

INSURANCE INFORMATION:

*Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will **NEVER** bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.*

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID#_____

Subscriber Name _____ Birthdate: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Zachary Fackler and/or Sidnie Morris all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company/(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to Black & Gold Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____

Patient Signature Date

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Patient Signature Date

Financial Responsibility

Patient Name_____

Dear Patient,
Black & Gold Chiropractic & Wellness provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

Consent to Release & Disclosure of PHI (Protected Health Information)

I hereby give my consent to Black & Gold Chiropractic and its representatives to share my health record with the following individuals only at my request:

Name: _____ Phone: (____) - _____ - _____

Relationship to patient: _____ Email: _____

Name: _____ Phone: (____) - _____ - _____

Relationship to patient: _____ Email: _____

Name: _____ Phone: (____) - _____ - _____

Relationship to patient: _____ Email: _____

_____ _____
Patient Signature Date

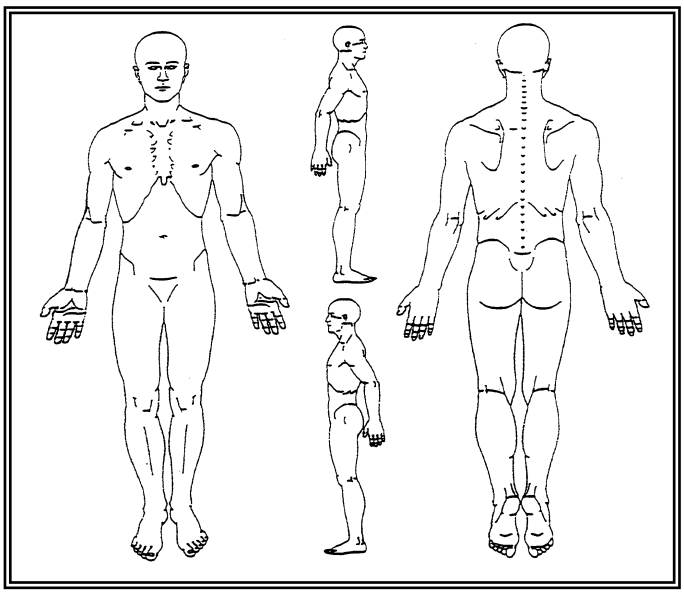
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, Select the pain level you experience when your problem is at its very worst:

- ☐ **0** = **No Pain**. No Discomfort
- ☐ **1** = **Minimal Discomfort**. Minor stiffness or tightness.
- ☐ **2** = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
- ☐ More than just sore. Uncomfortable.
- ☐ **4** = **Mild Pain**. Noticeable pain but tolerable.
- ☐ **5** = **Moderate Pain**. Aggravating. Still allows movement.
- ☐ **6** = **Strong Pain**. Quite aggravating. Movement slightly limited.
- ☐ **7** = **Very Strong Pain**. Very aggravating. Movement definitely limited.
- ☐ **8** = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
- ☐ **9** = **Severe Pain**. Brings tears. Almost impossible to move.
- ☐ **10** = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? ___ **Is there any numbness or tingling?** ___

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time) ◯ Body Location(s): _____

Frequent (50 – 75% of the time) ◯ Body Location(s): _____

Occasional (25 – 50% of the time) ◯ Body Location(s): _____

Intermittent (0 – 25% of the time) ◯ Body Location(s): _____

List any MD's or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV ☐None ☐Other _____

What makes your problem worse? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting ☐Reaching ☐Driving ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit to Stand ☐Sleeping ☐Other _____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life: _____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? **If yes, please list:** _____

List any medications, herbs or supplements you are taking and the reason for their use:

_____

_____

FAMILY HISTORY

Mother: ◯Living ◯Deceased List any medical problems: _____

Father: ◯Living ◯Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis ☐Other _____

SOCIAL HISTORY

Marital status: ◯Married ◯Single ◯Divorced ◯Common Law ◯Engaged ◯Widowed

Do you have any children? If yes, how many? _____

Do you drink alcohol? If yes, how much & how often? _____

Do you smoke? If yes, how much, how often & how long? _____

Are you currently employed? If yes, Occupation has already been specified on page 1.

Who is your current employer? _____ **How long have you been at this job?** _____

What do you do most of the day in your job postures, positions and repetitive movements: _____-

_____

I am looking for the following type of care:

☐ Acute symptom relief (short-term care)
☐ Corrective Care (symptom relief + spinal correction
☐ Doctor to determine best care recommendations

REVIEW OF SYSTEMS

Please use the criteria below to list each symptom on this page according to your health status:
C= Current Issue P= Past Issue

___Headaches	___Ear Infections	___Sinus Issues	___Kidney Problems	___Sexual Dysfunction
___Migraines	___Hear Loss	___Frequent Colds	___Bladder Problems	___Sleep Problems
___Jaw/TMJ Pain	___Ringing in the Ears	___Thyroid Issues	___Menstrual Problems	___Tight/Sore Muscles
___Neck Pain	___Dizziness	___Asthma	___Prostate Problems	___Sports Injury
___Shoulder Pain	___Loss of Energy	___Chest Pain	___Infertility	___Sciatica
___Arm Pain	___Nervousness	___Heart Problems	___Fibromyalgia	___Arthritis/Joint Pain
___Upper Back Pain	___Double/Blurry Vis.	___Nausea	___Epilepsy/Convuls.	___GERD/Gastric Ref.
___Mid Back Pain	___Anxiety	___Ulcers	___Tremors	___Difficulty Breathing
___Low Back Pain	___ADD/ADHD	___Digestive Issues	___Disc Problems	___Stomach Problems
___Hip/Leg Pain	___Loss of Balance	___Diarrhea	___Scoliosis	___High/Low Blood Pr.
___Knee Pain	___Depression	___Constipation	___Poor Posture	___Heart Attack
___Foot Pain	___Allergies	___Bed Wetting	___Skin Problems	___Stroke
___Cancer	___Spinal Surgery	___Diabetes	___Arthritis	___Seizures
___Spinal/Bone Fracture		___Other: _____		
___Pregnant: Due Date:_____				