Davis County Spinal Care, PC

Client Information

Congratulations on your decision to see us!

Name____ Date_________

Birth Date_________________ Social Security #__________________

Address____

Home Phone______________ Work Phone________________Cell________________

(Please circle the phone number that is best to reach you during our office hours.)

How did you discover our office?____

Reason for consulting our office today:____

What are your expectations for your care in this office?_______________________________

____

Please list any concerns in order of importance:

1.______________________ 2. _______________________ 3.______________________

Have you seen any other professional for these concerns? Y N

If yes, describe the treatment and any results:

____

Please check each of the following that has ever applied to your Health

☐ Sick a lot ☐ ADD/ ADHD ☐ School difficulties

☐ Earaches ☐ Poor balance or coordination ☐ Stress or Anxiety

☐ Sleeping difficulties ☐ Bed wetting ☐ Social fears/ problems

☐ Frequently unhappy ☐ Asthma/ Allergies ☐ Scoliosis/ Spinal problems

☐ X-rays or MRI ☐ Bone fracture ☐ Car accident

☐ Spinal or Head injury ☐ Falls ☐ Neurological conditions

☐ Birth Trauma (forceps, vacuum, c-section) ☐ Slow development

☐ Headaches

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your Health.

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Has you ever been to a Chiropractor before? Y N When____________________

Why did you go?____

What were the results?____

Why did you stop going?____

Do you have any conditions that may alter the way in which your care is delivered?

____

Please describe your:

Sleep____

Diet____

Exercise____

Do you take any vitamins, supplements, or medications? (Please explain)

____

Do you participate in any sports, lessons, talents, or hobbies? (Please explain)

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What is it that you want most for your Health?

____

Is there anything else that we need to know about you that was not addressed on this form?

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Payment Policy

Payment is due at the time of, or previous to, services being rendered. Before any Professional services are rendered all fees will be explained. If you have insurance you may be able to be reimbursed for part of your expenses at our office.

We ask that you kindly give 24 hours notice to change an appointment. Office policy is that missed appointments that are not cancelled or rescheduled with 24 hours notice are subject to a $20 fee for each 10 minute time period scheduled.

Our office is constantly improving; therefore all policies are subject to change (for the better ☺).

Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather we care for the spine for the sole purpose of removing interference with and tension from the Nervous System. We also employ extremity work to improve muscle and joint stability and function. Every person is better with improved neural, and musculo-skeletal function and this alone justifies our care. Research studies report improved health and wellness that is consistent with the care given. However, just what specific benefits you will receive, no one can predict.

By my signature I give my consent to Davis County Spinal Care, PC to use my client information and for a Doctor of Chiropractic to examine my spine and extremities. If I choose to receive Chiropractic care, my payment for such services, in addition to my signature here; will serve as acknowledgment of my permission for a doctor of chiropractic to deliver such care to me.

Privacy Notice

Your health information is private and protected by law. Your health information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations in this office. You have a right to review your office file. You may restrict all or part of your health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

Each practitioner at Advanced Health Clinic, LLC is a private contractor and works separately. At times a client may benefit from the services of more than one practitioner. In the event a referral is made, I allow other practitioners to review my file and/or discuss my health needs with me or my chiropractor.

I have had a chance to ask questions about the privacy policy and I give my permission to Davis County Spinal Care, PC to disclose my protected health information in accordance with such policies.

____
Signature Date

____
Witness Signature Date