HEALING TOUCH CHIROPRACTIC

1110 Hillcrest Rd Ste 1-F
Mobile, AL 36695

Dr. Michelle J. Patrick
251.289.1482

119 Professional Park Dr B
Fairhope, AL 36532

WELCOME

We are so glad you are here. We look forward to helping you.
In order for us to best help you, we need to know as much as we can about you.

PATIENT INFORMATION

Last Name:	First Name:	Nickname:	Date:
Title: Mr. Ms. Mrs. Dr. Male Female		Date of Birth:	SSN:
Status: S M D W	Spouse:	Spouse DOB:	Kids Names & Ages:
Address:			
City:	State:	Zip:	
Phone (H):	Phone (W):	Phone (C):	Preferred: H W C
Email:		Occupation:	Employer:
How were you referred to our office:			

CHIEF MEDICAL COMPLAINT

Please describe ONLY ONE Complaint per section.

COMPLAINT #1
What is the main problem that brings you into the office today?
Rate your pain (1-10, 1 being mild, please see attached pain scale):
Describe the pain type (sharp, dull, etc.):
Does the pain travel anywhere?
Is the pain constant or intermittent?
Is the pain getting better, worse, or staying the same?
How did this start?
When did this start?
When is the pain the worst (morning, afternoon, evening, middle of night, etc.)?
What makes it worse?
What makes it better?
Who have you seen for this condition? Chiropractor: _____ MD: _____ Other: _____
Doctor Name: Address:
What was the diagnosis?
What normal day to day activities can you not do because of this pain?

COMPLAINT #2
What other problems bring you into the office today?
Rate your pain (1-10, 1 being mild, please see attached pain scale):
Describe the pain type (sharp, dull, etc.):
Does the pain travel anywhere?
Is the pain constant or intermittent?
Is the pain getting better, worse, or staying the same?
How did this start?
When did this start?

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When is the pain the worst (morning, afternoon, evening, middle of night, etc.)?
What makes it worse?
What makes it better?
Who have you seen for this condition? Chiropractor: _____ MD: _____ Other: _____
Doctor Name: Address:
What was the diagnosis?
What normal day to day activities can you not do because of this pain?

COMPLAINT #3
What other problems bring you into the office today?
Rate your pain (1-10, 1 being mild, please see attached pain scale):
Describe the pain type (sharp, dull, etc.):
Does the pain travel anywhere?
Is the pain constant or intermittent?
Is the pain getting better, worse, or staying the same?
How did this start?
When did this start?
When is the pain the worst (morning, afternoon, evening, middle of night, etc.)?
What makes it worse?
What makes it better?
Who have you seen for this condition? Chiropractor: _____ MD: _____ Other: _____
Doctor Name: Address:
What was the diagnosis?
What normal day to day activities can you not do because of this pain?

COMPLAINT #4
What other problems bring you into the office today?
Rate your pain (1-10, 1 being mild, please see attached pain scale):
Describe the pain type (sharp, dull, etc.):
Does the pain travel anywhere?
Is the pain constant or intermittent?
Is the pain getting better, worse, or staying the same?
How did this start?
When did this start?
When is the pain the worst (morning, afternoon, evening, middle of night, etc.)?
What makes it worse?
What makes it better?
Who have you seen for this condition? Chiropractor: _____ MD: _____ Other: _____
Doctor Name: Address:
What was the diagnosis?
What normal day to day activities can you not do because of this pain?

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PAST MEDICAL HISTORY

Any Surgery or Hospitalization:	Year:	Residual Problem:

Work or Auto Injuries:

Other Traumas (broken bones/fractures, dislocations, concussions, sports injuries, sprain/strains):

Have you seen a doctor in the last 12 months? Yes No If yes, when? for what?

Diagnosed Medical Conditions:

Allergies:

Vitamins	Taken For	OTC Meds	Taken For	Medications	Taken For

FAMILY MEDICAL HISTORY

Please list the family members (*parents, siblings, and children*) who have had:

Cancer:	Clotting Disorder:	Dementia/Alzheimer's:
Diabetes:	Gastrointestinal disorder:	Heart Disease:
High Blood Pressure:	Kidney Disease:	Lung Disease:
Osteoporosis:	Psychological Disorder:	Septicemia:
Stroke:	SIDS:	Other:

SOCIAL HEALTH HISTORY

Height:	Weight:	
Maximum Nutrient Intake & Sufficient Water Intake		
What is a typical breakfast?	Mid-morning snack?	
Lunch?	Afternoon snack?	Dinner?
How many ounces of water do you drink each day?	Soda? Sweet tea?	Coffee?
Do you know what GMO & Non-GMO food is?	What percent of your diet is organic?	
Moving Daily		
Do you exercise: Never Seldom Occasionally Frequently		
Do you stretch regularly?		
Sufficient Quality Sleep		
How much sleep do you get each night?	Are you sleeping well or getting good quality sleep?	
Minimum Toxin Exposure		
What toxins are you aware that you are exposed to?		
Do you use tobacco products? Y N	If so, type?	How much?
Do you drink alcohol? Y N	How often?	

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REVIEW OF SYSTEMS

(Please check any you experienced in the last 12 months or been diagnosed with.)

GENERAL
- ☐ Weakness
- ☐ Fatigue
- ☐ Night sweats
- ☐ Weight changes
- ☐ *Cancer:* _____
- ☐ *Tumors or growths*

IMMUNE
- ☐ Fever/Chills
- ☐ Frequently sick
- ☐ Antibiotic use
- ☐ Chronic infection
- ☐ Autoimmune: _____

SKIN
- ☐ Rashes/Hives
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Dandruff
- ☐ Acne
- ☐ Hair changes
- ☐ Nail changes

HEAD
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Fainting
- ☐ Loss of memory

PSYCHIATRIC
- ☐ *Nervousness/anxiety*
- ☐ *Depression*
- ☐ Sleeping problems
- ☐ Insomnia
- ☐ Irritability
- ☐ Mood swings

EYES
- ☐ Changes in vision
- ☐ Redness
- ☐ Eyes water
- ☐ Double vision
- ☐ Light bothers eyes
- ☐ Dry eyes

MOUTH/THROAT
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Teeth grinding
- ☐ Jaw clicks/locks
- ☐ Loss of taste
- ☐ Tooth pain

EARS
- ☐ Ear Infections
- ☐ Changes in hearing
- ☐ Pain
- ☐ Discharge
- ☐ Ringing
- ☐ Vertigo

NOSE/SINUSES
- ☐ *Allergies*
- ☐ *Sinus trouble/infections*
- ☐ Nasal congestion
- ☐ Hay fever
- ☐ Nose bleeds
- ☐ Loss of smell

BREASTS
- ☐ Lumps
- ☐ Discharge
- ☐ Pain
- ☐ Skin changes

LUNGS
- ☐ Cough
- ☐ Cough up phlegm
- ☐ Cough up blood
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ *Asthma*
- ☐ COPD
- ☐ Emphysema

HEART
- ☐ *Chest pain*
- ☐ Palpitations
- ☐ Heart disease
- ☐ *High blood pressure*
- ☐ Low blood pressure
- ☐ Heart failure (CHF)

ILLNESSES
- ☐ *Tuberculosis*
- ☐ *HIV/AIDS*
- ☐ *Scarlet Fever*

DIGESTIVE TRACT
- ☐ *Diarrhea*
- ☐ *Constipation*
- ☐ Vomiting
- ☐ Bad breath
- ☐ Heartburn/GERD
- ☐ Jaundice
- ☐ Black/tarry stool
- ☐ Bleeding
- ☐ *Ulcers*
- ☐ Hemorrhoids
- ☐ Stomach upset
- ☐ *Bowel incontinence*
- ☐ *High cholesterol*
- ☐ *Hepatitis*
- ☐ IBS
- ☐ Crohn's

BLADDER
- ☐ Visible blood
- ☐ Burning
- ☐ Urinary habits changed
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Urgency
- ☐ Frequency
- ☐ Bedwetting
- ☐ Kidney stones
- ☐ Kidney failure

REPRODUCTION
- ☐ Irregular menses
- ☐ *Menstrual pain/cramps*
- ☐ Heavy menses/clotting
- ☐ Bleeding between cycles
- ☐ Uterine fibroids
- ☐ PMS
- ☐ Ovarian cysts
- ☐ PCOS
- ☐ *Reproductive disorders*
- ☐ *Infertility*
- ☐ Sexual dysfunction
- ☐ Hot flashes
- ☐ Menopausal symptoms
- ☐ *Venereal disease*
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal order

BLOOD/LYMPHATICS
- ☐ Leg cramps
- ☐ Swelling
- ☐ Blood clots
- ☐ *Stroke*
- ☐ Cold hands/feet
- ☐ *Anemia*
- ☐ Bleeding problems
- ☐ Bruising easily
- ☐ Swollen glands

BONE/MUSCLES
- ☐ *Rheumatoid*
- ☐ Osteoarthritis
- ☐ *Arthritis:*_____
- ☐ Muscle weakness
- ☐ Muscle pain
- ☐ Cramps/Charlie Horses
- ☐ *Back pain*
- ☐ *Neck pain*
- ☐ Stiffness
- ☐ Tension
- ☐ *Osteoporosis*
- ☐ Osteopenia
- ☐ Last bone scan: ____
- ☐ *Herniated disc*
- ☐ Degenerative disc
- ☐ *Fibromyalgia*
- ☐ *Muscular dystrophy*
- ☐ *Scoliosis*

NEUROLOGIC
- ☐ *Headaches*
- ☐ *Migraine* w/ aura
- ☐ Migraine no aura
- ☐ Migraine w/ vomiting
- ☐ Migraine > 72 hours
- ☐ Migraine relieved meds
- ☐ *Convulsions/seizures*
- ☐ *Numbness:* _____
- ☐ Tingling: _____
- ☐ Pins/needles legs
- ☐ Pins/needles arms
- ☐ Paralysis
- ☐ Tremors
- ☐ *Parkinson's*
- ☐ *MS*

GLANDS
- ☐ Intolerance to heat
- ☐ Intolerance to cold
- ☐ Change in appetite
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Diabetes
- ☐ Face flushing
- ☐ Easily stressed
- ☐ *Thyroid problems*

OTHER MEDICAL CONDITIONS

PROBLEMS: _____

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Financial Policy & Chiropractic Active Life Plans

We, Healing Touch Chiropractic, are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal while maintaining compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines. Our financial policies are as follows:

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You will be expected to pay for your chiropractic care at the time service is rendered unless you arrange an Active Life Plan in advance.
- Active Life Plans include yearly Corrective Adjustment Plans (CAP), monthly CAPs, and extended payment plans. These Active Live Plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report of Findings.
- Health Insurance: If you have insurance that covers chiropractic, we will work with you to enable you to utilize all benefits under your plan. Our office will bill your insurance company directly and accept payments directly from it. If your insurance company does not pay as expected, all charges due will be your responsibility.
- You may be entitled to a network or contractual discount under the following circumstances:
    - If we are a participating provider in your health plan.
    - If you are covered by a State or Federal program with a mandated fee schedule.
    - If you have an established, current hardship discount through Victory Health Partners. Verification will be required.
    - If you are a member of Chiro Health USA, a Discount Medical Program, that we are a network provider of. Patients who are uninsured or underinsured (limited benefits for chiropractic care) will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
    - If you or a family member serve in our military and that qualifies you for Patriot Project Benefits.

  As part of our compliance plan, as of 7/6/17 our office will be unable to extend any type of discounts other than those listed above.
- If you need a statement of your account just ask and we will promptly print one for you.
- We work very hard to keep our fees as low as possible. It is the goal of this office to not have money as a barrier to care. If you should ever have concerns about finances, please

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feel free to talk to our doctors or staff. We will help you in any way possible to enable you to continue care as needed.

- If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort. If this option must be used, a fee of up to, but no more than 50% of the balance owed by you will be added to your account. We will always work with you to get your account paid in full.

I understand that health and accident insurance policies are an arrangement between my insurance company and myself – not with this office. I authorize Healing Touch Chiropractic to release any medical information and to complete customary reports to assist me in collection from my insurance company. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

I understand that Healing Touch Chiropractic has a 24-hour cancellation policy and I may be billed for any missed appointment.

I have read and understand the above policies.

_____
Patient Name

_____ _____
Patient Signature Date

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Terms of Acceptance & Informed Consent

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 able to attain it. This will prevent any confusion or disappointment.

Subluxation (Vertebral or Extremity): A misalignment of one or more of the 24 vertebra in the spinal column or at an extremity joint 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any condition other than subluxation. However, if during the course of a chiropractic spinal evaluation, 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 subluxations of the vertebrae and extremity joints.

In addition to chiropractic care, our office offers additional services that are beneficial to our patients under the scope of our chiropractic licensees. These include: acupuncture, electrical stimulation, cold laser therapy, hot/cold packs, therapeutic massage/exercises, and applied nutritional analysis. As a patient of Healing Touch Chiropractic, I give the physicians and staff the authority to treat me in accordance with tests, diagnosis and analysis. The clinical procedures described previously are in most cases beneficial and rarely cause problems or injury. In these rare cases, problem or injury may be due to underlying physical defects, deformities, illnesses and/or pathologies. As a patient, I understand it is my responsibility to make such conditions, which would not otherwise be discovered or obvious, known to the physicians prior to treatment. I understand that by being accepted as a patient, I am authorizing Healing Touch Chiropractic to proceed with any treatment that may be deemed necessary. I also understand that I have the right to have any questions about treatments or procedures fully explained to me.

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I, _____, have read and fully understand the above statements of
(print name of person completing form) this informed consent.

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 and treatment from Healing Touch Chiropractic on this basis. I consent to a professional and complete chiropractic examination, to any radiographic examination, chiropractic treatment including adjustments as well as acupuncture, applied nutritional analysis, therapeutic massage, therapeutic exercises, and therapies such as electric stimulation, cold laser therapy, and hot/cold packs that the doctor deems necessary.

_____

Patient or Legally Authorized Individual Signature Date

For Patient's under 18 years of age:
I do hereby state that I have legal custody of the minor, _____. I grant my authorization and consent for the aforementioned minor to receive chiropractic services deemed necessary by Healing Touch Chiropractic.

_____

Patient or Legally Authorized Individual Signature Date

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Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Healing Touch Chiropractic, PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

I understand that, and consent to, the following appointment reminders or communications that will be used by this office: postcard mailed to me at my provided address, telephoning my home and leaving a message on my answering machine or with the individual answering the phone, texting my designated cell phone number; and/or emailing my designated email address. In addition, I give Healing Touch Chiropractic permission to sign me up for ChiroVoice.org.

Notice of Privacy Practices

You should review the Notice of Patient Privacy Policy that will be provided for a more complete description how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I acknowledge receipt of the 'Notice of Patient Privacy Policy.'

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Treatment Location

Note that some of your treatment may be performed in an 'open' area. Private areas are always available to discuss your health information upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date