CONFIDENTIAL PATIENT INFORMATION

Legal Name: _____ Preferred Name: _____
Preferred Phone:_____ Secondary Phone: _____
Address _____City/State _____ Zip _____ S.S.#_____
Birth Date_____ Age _____ Gender: _____ Race: _____ Ethnicity: _____
Marital Status M S W D How many children? _____Occupation_____ Employer_____
Name of Spouse _____ Occupation _____ Employer_____
Email Address_____ Who may we thank for referring you? _____
Have you had chiropractic care in the past? ☐ Yes ☐ No If so, who was the doctor and when? _____
Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
When did symptoms first start? _____ Have you had the same symptoms in the past? ☐ Y ☐ N When: _____

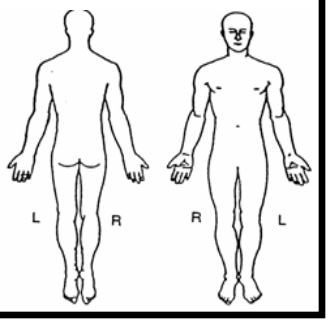
From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describe the pain: ☐ constant ☐ it comes and goes

☐ Sharp ☐Stabbing ☐ Throbbing ☐ Shooting ☐ Vague constant discomfort ☐ Burning
☐ Dull ☐ Achy ☐ Tingling ☐ Numbness Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
What makes it Better: _____ Worse:_____
Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing
☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____
What other treatment have you had for this condition: _____
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



SECONDARY CONDITION (If Applicable)
Please describe your primary complaint: _____

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
When did symptoms first start? _____ Have you had the same symptoms in the past? ☐ Y ☐ N When: _____

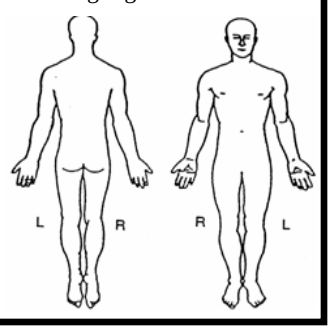
From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describe the pain: ☐ constant ☐ it comes and goes

☐ Sharp ☐Stabbing ☐ Throbbing ☐ Shooting ☐ Vague constant discomfort ☐ Burning
☐ Dull ☐ Achy ☐ Tingling ☐ Numbness Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
What makes it Better: _____ Worse:_____
Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing
☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____
What other treatment have you had for this condition: _____
☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



ADDITIONAL CONDITION (If applicable)

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

Please describe any additional complaint: _____

When did symptoms first start? _____ Have you had the same symptoms in the past? ☐ Y ☐ N When: _____

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain: ☐ constant ☐ it comes and goes

☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Vague constant discomfort ☐ Burning

☐ Dull ☐ Achy ☐ Tingling ☐ Numbness Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

What makes it Better: _____ Worse:_____

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

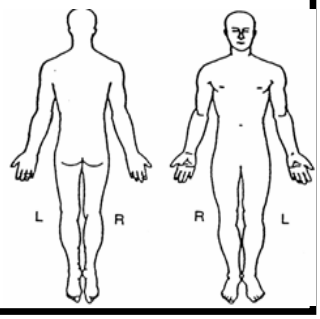
Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____

What other treatment have you had for this condition: _____

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Medication: Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Nutrients: Please list all nutrients you are currently taking. We offer the evaluate the formulations of your supplementation. If you desire this evaluation please bring your nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Family History/Review of Systems: Insert age and check any box that applies

	Age (if living)	Heart Disease	High Cholesterol	High Blood Pressure	Diabetes	Cancer	Anemia	Neck Pain	LowBack Pain	Carpal Tunnel	Headaches	Obesity	Neurological Disease	Stomach/Bowel	Skin Disease	Autoimmune	Depression/ Anxiety	Respiratory Problems	Stroke
Self																			
Mom																			
Dad																			
Brother																			
Sister																			
Other _____																			

Female Only:

Are you currently having menstrual cycles? __Yes __ No If yes, when was the first day of your last cycle? _____

Is there any chance you are pregnant? _____ Yes _____ No **If no, please sign here**:_____

Authorization for Care of Minor:

I hereby authorize this office and it's doctors to administer care to my child as they deem necessary.

Signed: _____ Witnessed: _____ Date: _____

REVIEW OF SYSTEMS

Name:_____ DOB:_____ Date:_____

Please check all symptoms you have experienced in the last <u>MONTH</u>

Constitutional/General
□ Fever
□ Chills
□ Heavy sweating/night sweats
□ Loss of appetite
□ Sleep disturbances
□ Unexplained weight loss/gain
□ Other: _____

Eyes
□ Blurry vision
□ Double vision
□ Wear glasses
□ Other: _____

Ear/Nose/Throat
□ Sore throat
□ Mouth sores
□ Nasal congestion/sinus issues
□ Hearing loss
□ Other: _____

Respiratory
□ Cough
□ COPD
□ Wheezing
□ Recurrent upper respiratory infections
□ Shortness of breath
□ Other: _____

Endocrine
□ Excessive thirst of fluid intake
□ Temperature intolerance
□ Fatigue
□ Hot flashes
□ Other: _____

Cardiovascular
□ Chest pain or discomfort
□ Swelling of feet, ankles or legs
□ Irregular heart beat
□ Heart attack
□ Heart failure
□ Palpitation
□ Varicose veins
□ Other: _____

Gastrointestinal
□ Abdominal pain
□ Nausea/vomiting
□ Indigestion or heartburn
□ Blood in stools
□ Change in bowel habits
□ Rectal bleeding
□ Diarrhea
□ Constipation
□ Swallowing difficulties
□ Other: _____

Psychological
□ Depression
□ Anxiety
□ Other: _____

Hematologic/Lymphatic
□ Swollen glands
□ Blood clotting problem
□ Easy bruising
□ Bleeding tendencies
□ Other: _____

Genitourinary
□ Painful urination
□ Urinary frequency
□ Loss of urinary control
□ Enlarged prostate
□ Difficulty urinating
□ Other: _____

Skin
□ Skin rash
□ Itching
□ Discoloration of the skin
□ Lumps or masses
□ Other: _____

Musculoskeletal
□ Joint pain
□ Joint swelling
□ Back pain
□ Limitation of motion
□ Neck pain
□ Pain with walking
□ Other: _____

Neurological
□ Tremors
□ Dizzy spells
□ Numbness or tingling
□ Headache
□ Unsteady gait
□ Feeling weak
□ Convulsions/seizure
□ Other: _____

Patient/Parent Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic 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: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. 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.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.getyourhealthsolutions.com

I have read and understand the information above.

Print Name:_____ Sign:_____ Date:_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

To: Health Solutions

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Print Name:_____ Sign:_____ Date:_____

FINANCIAL ARRANGEMENT

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility.

I have read and understand the statements above and give the doctor permission to evaluate me.

Name: _____ Signature: _____ Date: _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting in us for your chiropractic care. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Any established patient who fails to show or cancels/reschedules an appointment for an adjustment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25.00 fee.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact us 24 hours a day, 7 days a week at 309-284-0707 and may leave a message if we are unavailable.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Name: _____ Signature: _____ Date: _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

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

1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice:
    - Postcards mailed to the addresses I have provided.
    - Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
    - Email, text and/or portal communications via EHR software at the phone number and email address I have provided.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.
6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.
7. I give Health Solutions permission to treat me in an room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations
8. The doctor recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.
9. I authorize this office to communicate to my primary physician about the care I receive if information is requested.

    Primary physician: _____ City:_____

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Name: _____ Signature: _____ Patient DOB:_____ Date: _____