

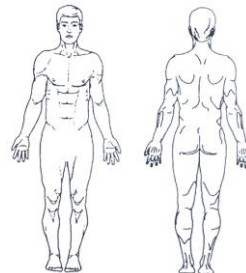
Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____ Date of Birth _____ Age (____)
 Referred by Friend/Family _____ Yelp Google Other Search Engine Facebook Instagram Groupon Event _____ PhoneBook
 Occupation _____ Employer _____
 Marital Status Single Married Divorced Widowed Spouse's Name _____
 Spouse's Occupation _____ Number of Children & Ages _____
 Have you ever received Chiropractic Care? Yes No When & Where _____ Date of last X-ray _____
 Social Security # _____ E-Mail Address _____

Symptoms and Ill Health (Present State)

Major Complaint _____
 Pain or problem started _____
 Pains are Sharp Dull Constant Intermittent (frequency _____)
 Does the pain radiate? Yes No
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is the condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is the condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____
 Other symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Jaw Problems	<input type="checkbox"/> Neck Pain/Tension	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Numbness in Toes
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Lights Bother Eyes	<input type="checkbox"/> Pins & Needles in Arms	<input type="checkbox"/> Pins & Needles in legs
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hands or Feet Cold
<input type="checkbox"/> Depression	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Stomach Upset
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Constipation/Diarrhea
<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Allergies	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Sudden Weight Gain/Loss	<input type="checkbox"/> Fever

Please indicate where your complaint is on the following diagram:



Please rate the pain on the following scale:
No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **The Worst Pain Ever**
 Have you been under drug and medical care? _____
 What medications are you taking? _____
 How Long? _____ Have you had surgery? _____ What _____ When _____

Loss of Whole Body Health (Birth – Present)

Name _____ Date _____

Yes	No		Patient Comment
<input type="checkbox"/>	<input type="checkbox"/>	<u>Birth Process</u> Forceps, C-Section, Breach/cephalic?	_____

		<u>Growth & Development</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Major childhood illnesses?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Ear Infections?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse	_____
		How?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas? What? When?	_____

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (do you eat healthy foods?)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (Prescriptive or non-prescriptive)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____
		Sleeping posture <input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/> Back	
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems	_____

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most *recent* layer of Spinal and Neurological damage (Vertebral Subluxation Complex). This care usually reduces or eliminates the symptoms. Then **Reconstructive Care** begins which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your Empowerment Session. Then you'll be able to begin a course of care that fits your health goals.

Patient Signature _____ Date _____

For Office Use Only

Posture Findings _____

Bilateral Weight Scales Left _____ Right _____

Positive Ortho/Neuros _____

3 T's:

Thoughts (mental/emotional stressors): _____

Traumas (physical stressors): _____

Toxins (chemical/environmental stressors): _____

Health Goals _____



Introduction to the Office

Let us extend a warm and personal welcome to you on behalf of the 100% team! We want to provide you with the finest health care and we'll offer you many informative and entertaining educational opportunities.

First, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health objectives.

Secondly, this information will be useful in making decisions about your health for the rest of your life.

To begin this process, here are a few important terms and procedures as you begin care:

On your first visit we will gather information about you through our Initial Discovery (examination and consultation). There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

We will be giving you information and clinical data in the form of literature, personal and media presentations. These are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Just as we need to know about you, you should know about us. Chiropractic education currently consists of

three years of pre-Chiropractic college education in the biological sciences, followed by another five years of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

We have minimized paperwork in our office. However, there are clinical forms that must be filled out accurately for your health, legal and professional reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

- Treatment Only.** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.
- Prevention.** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- Maintaining Health.** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health.** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

Name _____ Date _____



Terms of Acceptance

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

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.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period: _____

Signature _____ Date _____



Patient Privacy Acknowledgement Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time.. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in or office.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refused to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic practice has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: _____ Date: _____

Patient Signature: _____

I acknowledge that I will receive a copy of my records on my second visit.

Patient _____

Should you agree to share your information with anyone, please list their names below.
