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CHIROPRACTIC

Introduction to the Office

Let us extend a warm and personal welcome to you on behalf of the Align Family Chiropractic 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 Session (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 bachelors degree in sciences. This is followed by another four years of Chiropractic education and clinical internship. We also like to keep our knowledge fresh with required continuing education for licensure each year as well as specified trainings to help our pregnancy, pediatric, family, adult, and nutritional patients.

We have tried to minimized paperwork in our office. There are clinical forms that must be filled out accurately are for your health, legal, insurance and professional reasons. 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_____

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Name_____Date_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____Work Phone (_____)_____Cell (_____)_____Date of Birth_____ Age (___)

Referred by Friend/Family_____ Yelp Google Provider Facebook Instagram Mom's Group Church Event Other_____

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_____

Is this visit due to an: Auto Accident Work Injury I prefer to be contacted via: Text Email Phone Call

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?_____

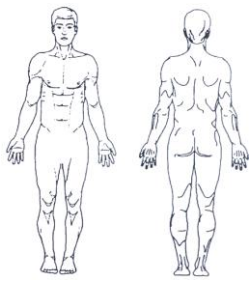
Other Doctors seen for this condition_____

Any home remedies?_____

Other symptoms:

☐ Headaches	☐ Jaw Problems	☐ Neck Pain/Tension	☐ Back Pain
☐ Dizziness/Fainting	☐ Eye Problems	☐ Thyroid Issues	☐ Numbness in Toes
☐ Nervousness	☐ Lights Bother Eyes	☐ Pins & Needles in Arms	☐ Pins & Needles in legs
☐ Fatigue	☐ Ears Ring	☐ Shortness of Breath	☐ Hands or Feet Cold
☐ Depression	☐ Hearing Problems	☐ Night Sweats	☐ Stomach Upset
☐ Sleeping Problems	☐ Loss of Memory	☐ High/Low Blood Pressure	☐ Constipation/Diarrhea
☐ Irritability	☐ Loss of Smell	☐ Chest Pain	☐ Loss of Balance
☐ Allergies	☐ Loss of Taste	☐ Sudden Weight Gain/Loss	☐ 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
		Birth Process (How were you born)	
☐	☐	Forceps, C-Section, Breach/cephalic?	_____
			_____
		Growth & Development	
☐	☐	Major childhood illnesses?	_____
☐	☐	Chronic Ear Infections?	_____
☐	☐	Sore Throats?	_____
☐	☐	Bedwetting?	_____
☐	☐	Accidents?	_____
☐	☐	Child abuse	_____
		How?	_____
☐	☐	Other traumas? What? When?	_____
			_____

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

Chiropractic provides three types of care. The first is **Acute Care** which corrects the most *recent* layer of Spinal and Neurological damage (Vertebral Subluxation Complex). This care usually reduces or eliminates the symptoms. Then **Restoration 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_____

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Terms of Acceptance

I hereby request and consent to chiropractic adjustments and other procedures by the Doctors and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Align Family personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Align Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Align Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

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,_____(parent) being the parent or legal guardian of _____(child) have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Guardian's Signature_____Date_____

IF YOU ARE PREGNANT...

Estimated Date_____ Other Providers _____

_____

_____

Signature_____Date_____

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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:_____

Patient_____

Should you agree to share your information with anyone, please list their names below. This can be editted/ amended at anytime.

_____ _____ _____

_____ _____ _____