PATIENT DETAILED INFORMATION

Last Name | First Name | MI | "Nickname"

Address | DOB

City | State | Zip/Postal Code | E-mail

Cell Phone | Height | Weight | SS # (Last 4)

Emergency contact | Primary contact # | Relationship to Patient

Marital Status:

Single | Married | Widowed | Divorced

How did you hear about us?

- ☐ Word of mouth
- ☐ Social Media
- ☐ Practitioner Referral
- ☐ Drive by
- ☐ Google
- ☐ Other _____

*If by word of mouth, whom may we thank for referring you to us?

What type of care are you looking for in our office?

- ☐ I only want Orthospinology (Upper Cervical)
- ☐ I only want Gonstead (Fullspine)
- ☐ I want a combination of the two based on the doctor's recommendations

Health Complaints

What is your PRIMARY complaint?

How long have you been experiencing this primary complaint?

Has this progressed over time? (worse/same/better)

What do you think caused your primary complaint?

What are your health goals with care?

What does success look like to you in terms of your health?

What activities are you no longer doing that you would like to do?

1. _____ 3. _____
2. _____ 4. _____

Is there medical history you want us to know about? (Personal or Family)

Have you suffered any head injuries? (including concussions): _____

Surgical History

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws) If yes, please explain:

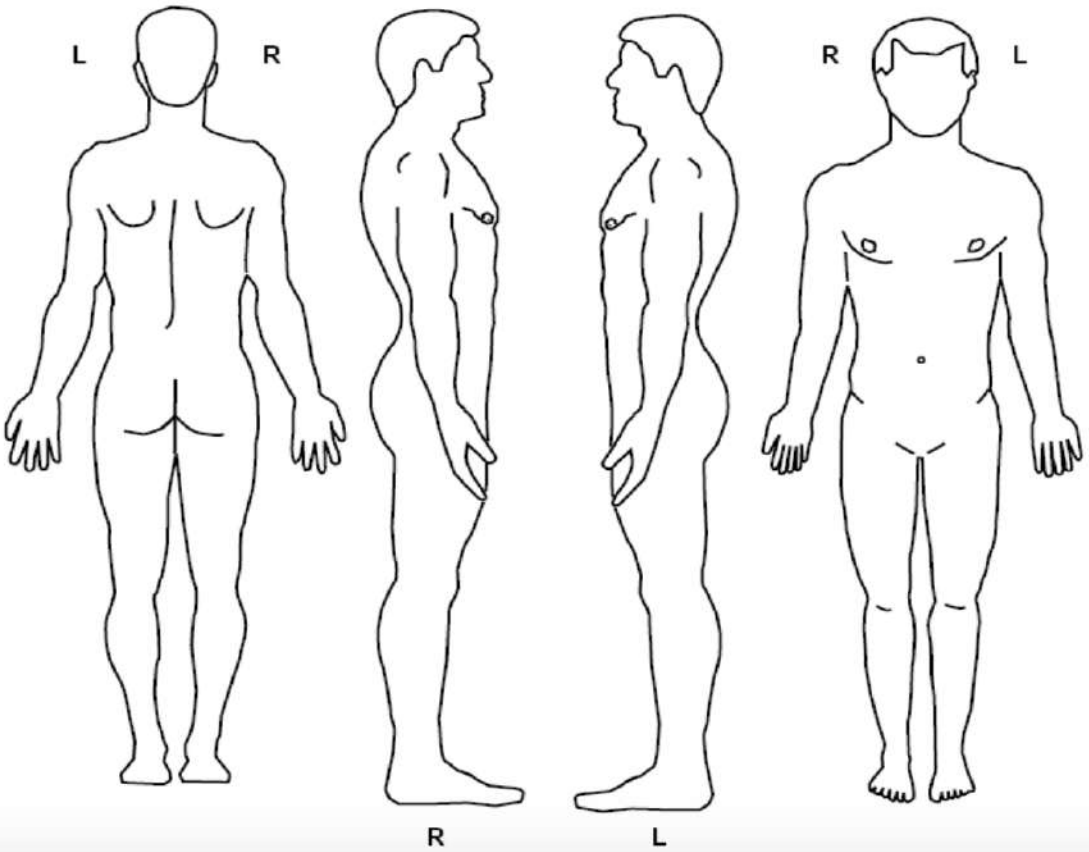
_____

List all of the previous surgical procedures as they pertain to you: _____

_____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness (N) **Tingling (T)** **Burning Pain (B)** **Stabbing Pain (S)** **Aching Pain (A)**



Lifestyle & Nutritional Habits

Occupational History:

Do you work? ☐ Yes ☐ No ☐ Disability ☐ Retired

Occupation(s): _____

Daily Habits:

On average, how many hours of sitting do you do you do per day? (computer work, TV, vehicle)

☐ <2 ☐ 2-4 ☐ 4-6 ☐ >6

On average how many hours of sleep do you get per night?

☐ <6 ☐ 7 ☐ 8 ☐ >8

Do you exercise? (Yes) or (No) If yes, how often?

☐ Daily ☐ 3-5x/wk. ☐ 2x/wk. ☐ 1x/wk.

If yes, how long are your workouts?

☐ < 0.5 hour 0.5-1hour ☐ 1-2hours ☐ >2 hours

What are your exercise activities? (mark all that apply)

- ☐ Walking
- ☐ Jogging/Running
- ☐ Swimming
- ☐ Biking
- ☐ Rowing
- ☐ Hiking
- ☐ Strength Training
- ☐ Stretching
- ☐ Yoga/Pilates
- ☐ Intramural Sports

Do you smoke tobacco? (Yes or No) If yes, How often? _____

Do you use recreational drugs? (Yes or No) How much? _____

How many ounces of water do you drink per day?

☐ <24 ☐ 24-48 ☐ 48-64 ☐ >64

Medications, Vitamins, Supplements

Please list any vitamins or supplements you are currently taking.

_____

_____

Please list any prescription or over-the-counter medications you are currently taking and the condition for which they are for.

_____

_____

I understand and agree to the following:

It is my responsibility to complete the clinic's forms accurately and provide the most up to date information.

It is my responsibility to notify the doctor if any of the information has changed or requires updating.

Patient Name (print)	Patient Signature	Date
Parent/Guardian (Print)	Parent/Guardian Signature	Date

Patient Appointment & Scheduling Policies

We value your time and appreciate the opportunity to care for you. To help us provide timely, consistent care for all of our patients, we kindly ask that you review and acknowledge the following appointment policies. These policies apply throughout your course of care.

1. Appointment Cancellations

We understand that schedules can change. If you need to cancel or reschedule an appointment, we ask that you provide **at least 24 hours' notice**. This allows us the opportunity to offer your appointment time to another patient.

Cancellations made with less than 24 hours' notice will be subject to a **$35 late cancellation fee**.

2. No-Show Policy

If you do not arrive for your scheduled appointment and **do not provide notice before the start of your appointment time**, the appointment will be considered a **no-show**.

Because that appointment time has been reserved specifically for you, a no-show will result in a charge for the **full price of the scheduled visit**.

3. Late Arrival & 5-Minute Grace Period

We understand that unexpected delays can happen. We offer a **5-minute grace period** for patients arriving late.

If you anticipate being **more than 5 minutes late**, please contact our office as soon as possible. In order to respect the schedules of our patients and doctors, appointments arriving more than 5 minutes late may need to be **rescheduled**. When rescheduling is necessary because of a late arrival, the **$35 late cancellation fee** will apply.

4. Scheduling With the Appropriate Doctor

Our doctors may have different schedules, services, and areas of focus. When making an appointment, please be sure to **book with the doctor you wish to see**.

If you would like to receive care from **both doctors**, you will need to schedule **two separate appointments**. Each appointment will be billed according to the appropriate fee for the doctor and service provided.

5. Payment is due at time of Service

We accept cash, check, credit card, debit card, FSA, HSA, and Care Credit. We do not bill or accept insurance.

Patient Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the appointment and scheduling policies outlined above. I understand that these policies are in place to help the office maintain an efficient schedule and provide the best possible care to all patients.

Patient Name: _____

Patient Signature: _____

Date: _____

HEALTH CARE AUTHORIZATION

As of April 14, 2003, the Federal Government requires a patient's signature to authorize being contacted by phone, mail, etc. This is a result of the Health Insurance Portability Act (HIPAA). The goal is to protect your personal health information.

PRINT PATIENT NAME _____
Last **First** **Middle**

Date of Birth _____ / _____ / _____

Specific Authorizations:
I give permission for Origins Chiropractic and Wellness to contact me by e-mail, phone or leave message on my voice-mail regarding my appointments and status of health. I also give permission to use my name and address to mail office and e-mail newsletters, referral cards, postcards, holiday related cards or information about health related issues.

Initial Here: _____

Patient Rights:

1. **You have the right to refuse to sign this authorization.** If you refuse to sign this Authorization, Origins Chiropractic and Wellness will not refuse to provide treatment.

2. **You have the right to revoke this authorization, in writing at any time.** You may revoke this Authorization by mailing or hand delivering a written notice to the Privacy Official of Origins Chiropractic and Wellness. The written notice should contain your name, Social Security number and date of birth. State your intent to revoke this authorization, then sign and date it. Once received, the Privacy Official will revoke the authorization.

3. **You have the right to a copy of this authorization.**

Patient Signature _____ **Date:** _____

Personal Representative Signature (if applicable) _____

For Office Use Only

Expiration-
This Authorization shall expire in 7 years. Expiration Date: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic's procedure often depends on underlying causes, patient compliance, as well as other spinal and physical conditions.

ADJUSTMENTS

The doctors utilize various techniques to adjust the spine. The techniques used are non-rotary done with hands or an instrument. Adjustments done by hand are considered high velocity low amplitude, non-rotary. Instrument adjustments are low force done to the upper cervical spine.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you agree to give the doctor permission and authority to care for you in accordance with the chiropractic tests and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects of pathologies may render a patient susceptible to injury. The doctor will not provide healthcare if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS

As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from you care. Chiropractic care is not a treatment of disease, but a system of correcting vertebral subluxations. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedure is superior to his fellow chiropractors.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or other healthcare professionals for the sake of case management. As a patient, you are giving the doctor permission to use his best judgement for when to allow an observer in the room or when it is necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT

Please discuss any question or problems with the doctor before signing this statement of policy. I have had the above explained to me and after reading it, I understand the foregoing and give my consent. I acknowledge that the doctor reserves the right to discontinue and/or refuse care in the event that it becomes unsafe to render care or I become noncompliant with the current care plan.

Date_____ Signature_____