Warnars Chiropractic Clinic

125 E. Capac Rd Imlay City, MI 48444 (810) 724-0996 Fax (810) 724-4343

Name:______________________________ Phone:______________________

Address:__________________________ City:______________ State:_______ Zip:_________

Date of Birth:____________________ Male / Female Marital Status M S W D

Social Security #:________________________ Spouse's Name:____________________

Occupation:________________________ Employer:__________________________

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other:______________________

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________

E-mail:______________________________ Referred by:____________________

Emergency Contact:__________________________ Phone:____________________

Insurance Information

Insurance Company:______________________________ Phone:__________________

Contract/ID #:__________________________ Group #:______________________

Name of Subscriber:______________________ Date of Birth:__________________

Personal Health History

Date of last physical exam:_______________ Doctor's Name:____________________

Have you ever been under Chiropractic care in the past? Y / N Doctor's name:__________________

Females: Are you pregnant? Y / N If yes, Due Date:_________ Date of last menstrual cycle:____________

Please check the conditions you are experiencing now or have in the past:

☐ Heart Attack	☐ Frequent Neck Pain	☐ Dizziness	☐ Congenital Heart Defect
☐ Gout	☐ Jaw Pain	☐ Emphysema	☐ Glaucoma
☐ Stroke	☐ Wrist Pain	☐ Kidney Problems	☐ Shingles
☐ Fainting	☐ Shoulder Pain	☐ Artificial Joints	☐ Varicose Veins
☐ Seizures	☐ Arm Pain	☐ Ulcer/Colitis	☐ Severe/Frequent Headaches
☐ fibromyalgia	☐ Leg Pain	☐ Ringing in ears	☐ Severe/Frequent Earaches
☐ Difficulty breathing	☐ Low Back Problems	☐ Loss of sleep	☐ Difficulty/Frequent Urination
☐ Arthritis	☐ Diabetes	☐ Cancer	☐ Hepatitis
☐ Anemia	☐ Tuberculosis	☐ Alcohol abuse	☐ Positive HIV/AIDS
☐ Psychiatric problems			

Tingling or Numbness: ☐ Shoulders ☐ Hips ☐Arms ☐ Legs ☐ Elbows ☐ Knees ☐ Hands ☐ Feet

Habits	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Do you currently:

Take Vitamins? Y / N

Think you need Vitamins? Y / N

Are you interested in a nutritional consultation? Y / N

Are you wearing?:

☐ Heel Lifts ☐ Arch Supports

☐ Orthotics ☐ Sole Lifts

List all prescribed and over-the-counter medications and conditions treated:

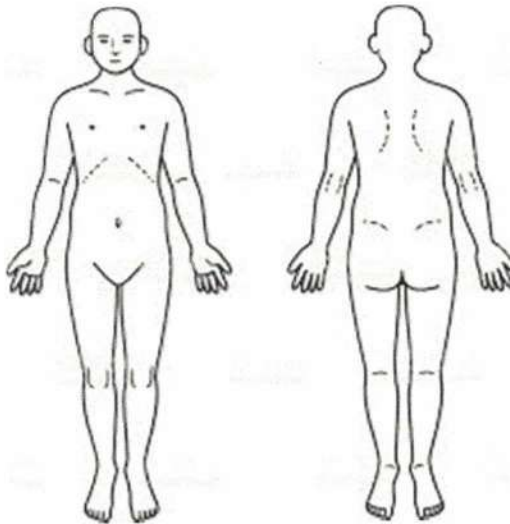
Medication	Reason
______________________________	______________________________
______________________________	______________________________

List all serious illnesses, surgical procedures, fractured bones or anything else you believe doctor should know:

Serious Illness/Surgical Procedure/Bone Fracture/Etc.	Date
______________________________	______________________________
______________________________	______________________________

Mark the areas on the diagram where you feel the following sensations:

A=Aches B=Burns N=Numbness T=Tingling O=Other
S=Sharp D=Dull C=Constant I=Intermittent



Date symptoms appeared:____________________

Have you experienced the same or similar symptoms in the past? Y / N If yes, when and describe:________
____

Have you missed any days from work? Y / N If yes, dates missed:______________________________

What activities aggravate your condition?____

Is this condition getting progressively worse? Y / N Constant Comes and Goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other:______________

How long has it been since you really felt good?____

What do you believe is wrong with you?____

Other doctors seen for this condition:____

Have you been treated for any health condition by a physician in the last year? Y / N

If yes, describe:____

Primary Care Physician:________________________________Phone:______________________

Send a Report? Y / N

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

Patient Initials__________

Assignment of Benefits

I authorize my insurance company to pay, to Warnars Chiropractic Clinic, all insurance benefits otherwise payable to me for services rendered. I authorized the use of this signature on all insurance submissions. I authorize Warnars Chiropractic Clinic to release all information necessary to secure the payment of benefits.

Patient Initials__________

Financial Responsibility

I understand that I am financially responsible for all charges whether covered by my insurance or not. I also understand that the relationship is between me and my insurance company and any verification of benefits, eligibility and claims disputes, is my responsibility.

Patient Initials__________

Informed Consent to Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million, cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Warnars Chiropractic Clinic, a health history and physical examination will be completed. These procedures are performed by members of our faculty and are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care, including spinal adjustments, as reported following my assessment. I understand that all Doctor and Chiropractic Assistants at Warnars Chiropractic Clinic could be involved in my care. I also understand that my condition and treatment could be used for training and/or educational purposes with my consent. My name and other personal identifying information will be kept confidential.

______________________________	______________________________
Patient Name (printed)	Relationship to patient
______________________________	______________________________
Patient or Legal Guardian Signature	Date
______________________________	______________________________
Witness	Date

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize the doctors at Warnars Chiropractic Clinic and whomever he/she may designate as their assistants to administer chiropractic care as he/she deems necessary to ______________________________, my minor.

Patient name

____

Parent or Legal Guardian Signature

HIPAA Compliance Patient Consent Form & Your Right to Obtain a Paper Copy

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You have the right to view a copy or request a paper copy of our Privacy Practices at any time.

Consent For Use or Disclosure

By placing my initials below, I acknowledge that I have read your consent policy as stated above, and further, I AGREE to its terms. I am also acknowledging that I have received a copy of this consent form and your privacy notice.

Patient Initials__________

Appointment Reminders/Health Care Information Authorization

By placing my initials below, I acknowledge that I have read your policies on telephone calls and text messages for appointment reminders and the use or disclosure of my health care information in the manner described above, and I AGREE to the terms as stated in this document. I am also acknowledging that I have received a copy of this authorization.

Patient Initials__________

Marketing Authorization

By placing my initials below, I AGREE and give my permission to the staff of Warnars Chiropractic Clinic to use my name, address, phone number, email and/or clinical records for the purpose of marketing products and services from Warnars Chiropractic Clinic alone. Warnars Chiropractic Clinic is specifically requesting my authorization to mail to my billing and/or home address, birthday cards, patient re-Activation cards and/or Information on new products or services being offered.

Patient Initials__________

Acknowledgement of Privacy Policies and Authorizations

This notice is effective as of today's date, which is noted below. This notice and the consents agreed to therein, will be active until any changes are made to Warnars Chiropractic Clinic's Privacy Policy, at which time this authorization will be void. By signing below, I acknowledge that I have received a copy of this notice.

______________________________	______________________________
Patient Name (Printed)	Relationship to Patient
______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Witness	Date