WELCOME

To *Northside Chiropractic*

Patient Information

Date_____

Patient Name_____
First Name

_____
Middle Initial Last Name

Address_____

Apt #_____ City_____

State _____ Zip _____

Home Phone _____

Work Phone_____

Cell Phone _____

Cell Phone Carrier _____(for text reminder's)

E-mail _____

Birthdate_____ Age _____

Sex M_____ F_____

Married ____ Single____ Divorced ____

Widowed ____ Separated ____ Partnered ____

Occupation_____

Employer _____

Address _____

Spouses Name _____

How did you hear about our office?

_____

In case of emergency contact

Name _____

Relationship _____

Phone number _____

Insurance Information

Please give your insurance card to the front desk staff to make a copy. _____
Initials

Social Security # _____

Do you have more than one insurance?_____

Is your condition due to an accident? _____

Date of Accident _____

Type of Accident: Auto_____

Work _____ At home _____

Assignment and Release

I assign directly to NORTHSIDE CHIROPRACTIC Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named Doctor may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent stands while I am a patient in this office.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print Name

_____ _____
Date Relationship to Patient

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is it progressively getting worse? _____ YES _____ NO

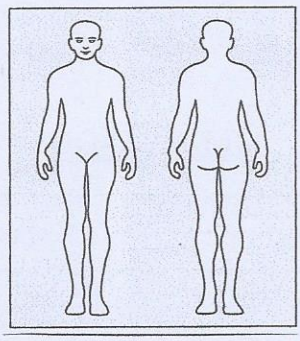
RATE the **severity of your pain** on a **SCALE** *from 1 (least) to 10 (severe)*:

1 2 3 4 5 6 7 8 9 10

Type of Pain: - Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Stabbing

How often is the pain? _____ Does it interfere with : Work Sleep
Daily Activities Recreation

Movements that are painful: Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for this condition? Medications Surgery Physical Therapy
Chiropractic None Other _____
Name of Doctor(s) or Facilities who have treated you for this condition _____
_____

Date of Last: Physical Exam _____ Spinal X-Ray _____
Spinal Exam _____ MRI, CT-Scan _____

Please check any that apply to you of the following:

- o Allergy Shots
- o Arthritis
- o Asthma
- o Bleeding Disorder
- o Cancer
- o Chemical Dependency
- o Chicken Pox
- o Depression
- o Diabetes
- o Epilepsy
- o Fractures
- o Glaucoma
- o Gout
- o Heart Attack
- o Heart Disease
- o Hernia
- o Herniated Disc
- o High Blood Pressure
- o High Cholesterol
- o Kidney Disease
- o Migraine Headaches
- o Multiple Sclerosis
- o Osteoporosis
- o Pacemaker
- o Parkinson's Disease
- o Pinched Nerve
- o Prostate Problems
- o Prosthesis
- o Psychiatric Care
- o Rheumatoid Arthritis
- o Sciatica
- o Stroke
- o Suicide Attempt
- o Thyroid Problems
- o Tumors
- o Ulcers

EXERCISE	WORK ACTIVITY	HABITS	
o None	o Sitting	o Smoking	Packs/Day_____
o Moderate	o Standing	o Alcohol	Drinks/Week_____
o Daily	o Light Labor	o Coffee/Caffeine	Cups/Day_____
o Heavy	o Heavy Labor	o High Stress Level	Reason_____

Are you pregnant? YES NO Due Date_____

INJURIES/ SURGERIES	DESCRIPTION	DATE
o Falls		
o Head/Back Injuries		
o Broken Bones		
o Dislocations		
o Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health 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. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of 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 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Referral services are separate from our business and individuals who may refer you to our company do not offer any expertise in advice, diagnosis and treatment of any disease or condition and patient fully releases any person making a referral from any and all liability. In the event the treating doctor refers the patient to another care provider, patient fully releases the treating doctor and our company from any and all liability.

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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

HIPAA Privacy Act Policy Summary

The HIPAA Federal Regulation requires that we explain how we may use and release your private health information. This summary is provided to give you a basic overview of what our Privacy Policy contains. For more information, you are encouraged to read the full Policy or contact our privacy officer.

OUR RIGHTS: We may use and disclose your health information to provide patient care and treatment, process payment collection and claims to your health plan or insurance company, comply with laws that require reporting of your health information, review your records for quality of care, and to inform you of health services that may interest you or would be beneficial.

YOUR RIGHTS: While the records we maintain about you belong to us, you have a number of rights with respect to those records. You have the right to: request a copy of our full Privacy Policy, see your record and request a copy, request we amend your records if you believe it is incomplete or incorrect, request that we send information to you in a confidential manner, request a copy of companies, attorneys, and providers we have released your information to, and complain to us and/or the Department of Health and Human Services if you believe we have violated your privacy rights.

OUR DUTIES: We must provide you with our Notice of Privacy Practices and abide by its terms. We may: charge a fee for copying your records, require up to 90 days to process you records, deny your request to amend your records for certain reasons and provide these reasons in writings, and amend the Privacy Policy at anytime and make copies of the changes available in writings.

Acknowledgement of HIPAA Notice of Privacy Practices

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the HIPAA Privacy Act Policy Summary. I acknowledge that I have the right to request a restriction of my protected health information. To restrict your health information in our office, please notify us.

☐ I would like the following entities to have access to my information:

_____

(Names of authorized individuals)

_____ _____

Patient Signature Date Guardian or Spouse's Signature

_____ _____

Patient Name (Printed) Witness (Office Staff)

AUTHORIZATION FOR 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, fracture. 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 adjustments, may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Northside Chiropractic, a health history and physical examination will be completed. This procedure is performed to assess your specific condition, your overall health and, in particular, your spine health. This procedure will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, it 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 prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent. I clearly understand and agree that all services rendered are my responsibility to pay. I authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient Signature Date

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays is for the examination of X-rays only. The X-ray negative will remain the property of this office. They are kept on file where they may be seen or borrowed at any time while I am a patient of this office.

_____

Initials