

NAME: _____ SEX: M / F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ CELL PHONE: () _____ CELL PHONE PROVIDER: _____

EMAIL ADDRESS: _____@_____ Subscribe for email/website notifications ☐ Yes ☐ No

HEIGHT: _____ WEIGHT: _____ BIRTHDATE: ____/____/____ MARITAL STATUS: Single Married Widowed Divorced
circle one

EMPLOYER: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?: _____

1. What is your main concern? _____

2. How long have you had this condition? _____

3. Have you lost work days: Yes/No How many? _____

4. Have you been experiencing any activity restrictions? (check all that apply)
____Lifting ____Standing ____Personal Grooming ____Sleeping ____Social Life ____Driving
____Sitting ____Bending ____Kneeling/Climbing ____Walking ____Sexual Activity ____In/Out of Vehicle

5. Was the injury related to: **Work Accident** ☐ Yes ☐ No **Auto Accident** ☐ Yes ☐ No **Other** ☐ Yes ☐ No
Please explain: _____
Describe what you feel caused this condition: _____

6. When did you last see a chiropractor? _____ Dr: _____
Why did you see this chiropractor? _____ Were you helped? Yes/No
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

Did you follow it? Yes/No If no, why? _____ Why are you changing Chiropractors? _____

7. Why did you come into our clinic and what are your expectations of us?

8. SOCIAL HISTORY:
What are your favorite hobbies or activities to do now? _____
Are your current problems affecting these activities or hobbies? Yes/No
Do you take nutritional supplements? Yes/No If yes, describe: _____
Are you on any special diets? Yes/No If yes, describe: _____
Are you currently wearing: Heel Lifts ____ Arch Supports ____
Do you smoke? Yes/No If yes, indicate number of packs a day: _____
Do you exercise? Yes/No If yes, describe: _____
Do you drink? Coffee: Yes/No, Tea: Yes/No, Alcoholic beverages: Yes/No,
Soda: Yes/No, If checked, how often _____
Do you sometimes feel that you do not have enough energy to get through the day? Yes/No

9. FAMILY HISTORY (please check those diseases that have affected you or your family).

____ Heart Disease	____ Epilepsy	____ Asthma	____ Sinus problems
____ Tuberculosis	____ Anemia	____ Retardation	____ Other
____ Cancer	____ Diabetes	____ HIV pos (AIDS)	_____
____ Psychiatric	____ Kidney disease	____ High blood pressure	
____ Overweight/Obesity	____ Anorexia/Bulimia	____ Circulatory Problem	

10. List all previous illnesses, injuries and hospitalizations/operations:

***Check all that apply**

Area of body/Symptoms	Date	Describe (include any medication)
A. <input type="checkbox"/> Fractured Bones <input type="checkbox"/> Auto Accidents <input type="checkbox"/> (a) -0-1 years ago <input type="checkbox"/> (b) -1.5 years ago <input type="checkbox"/> (c) -More than 5 years ago <input type="checkbox"/> Other Accidents/Falls <input type="checkbox"/> Knocked Unconscious <input type="checkbox"/> Back Curvature <input type="checkbox"/> Mental or Emotional Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Swollen or Painful Joints <input type="checkbox"/> Convulsions/Epilepsy <input type="checkbox"/> Skin Problems <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer <input type="checkbox"/> Frequent Colds/Flu <input type="checkbox"/> Itching B. <input type="checkbox"/> Nervous <input type="checkbox"/> Tension <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Anemia <input type="checkbox"/> Excess Sweating — Tremors <input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Sinus Problems <input type="checkbox"/> Allergy <input type="checkbox"/> Light Headed upon Rising <input type="checkbox"/> Under Stress <input type="checkbox"/> Crave Sweets or Salt <input type="checkbox"/> Eating Disorders C. <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Loss Of Memory <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Mistake Sides R/L <input type="checkbox"/> Stutter <input type="checkbox"/> Dyslexia <input type="checkbox"/> Mood Change <input type="checkbox"/> Lose Temper Easily D. <input type="checkbox"/> Headache <input type="checkbox"/> Neck Pain <input type="checkbox"/> Numbness, tingling, or pain <input type="checkbox"/> In arms __Hands __fingers R/L <input type="checkbox"/> Jaw pain or click R/L <input type="checkbox"/> Heads seems to heavy <input type="checkbox"/> Hip pain R/L <input type="checkbox"/> Head & Shoulders feel tired <input type="checkbox"/> Difficulty in bending, lifting, sitting, standing, walking, riding	<input type="checkbox"/> Shoulder Pain R/L <input type="checkbox"/> Foot trouble R/L <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears R/L <input type="checkbox"/> Hearing Loss R/L <input type="checkbox"/> Fainting <input type="checkbox"/> Blurred or double vision R/L <input type="checkbox"/> Upper back pain or arthritis R/L <input type="checkbox"/> Mid back pain or arthritis R/L <input type="checkbox"/> Lower back pain or arthritis R/L <input type="checkbox"/> Numbness, tingling or pain in buttocks, thighs, legs, feet, <input type="checkbox"/> Loss of Balance toes R/L <input type="checkbox"/> Pain w/cough, sneeze or Strain at stools E. <input type="checkbox"/> Chest pain <input type="checkbox"/> Asthma <input type="checkbox"/> Lung problems <input type="checkbox"/> Difficult Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Heart Problems <input type="checkbox"/> Stroke <input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Gall Bladder trouble
		F. <input type="checkbox"/> Digestive problems <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Belching/bloating after meals <input type="checkbox"/> Heartburn <input type="checkbox"/> Ulcers <input type="checkbox"/> Diarrhea/constipation <input type="checkbox"/> Colon trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence G. <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Discharge <input type="checkbox"/> Menstrual problems/PMS <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Breast: lumps, soreness <input type="checkbox"/> discharge <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bed wetting <input type="checkbox"/> Ear infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Other _____

11. Are you currently being treated by another doctor? Yes/No

If yes, Whom? _____ Why? _____

12. Are you currently taking any over the counter or prescription medication? Yes/No

If yes, What? _____ Why? _____

Name of Medication: _____ Taking for? _____

Name of Medication: _____ Taking for? _____

Name of Medication: _____ Taking for? _____

Name of Medication: _____ Taking for? _____

I WILL BE PAYING BY: ☐ CASH ☐ INSURANCE ☐ MEDICARE ☐ OTHER

If insurance, Name: _____ Policy # _____

I certify this information to be true and correct. I assign my benefit payments to be paid directly to **Summit Chiropractic Health Center**; however, I understand that I am ultimately responsible for payment of service rendered. I also authorize the release of any information which is required for payment. Furthermore, I understand that **Summit Chiropractic Health Center** is not claiming to be a cure-all for my symptoms, and there are no guarantees.

Patient or Guardian Signature

Date

Witness

Please feel free to discuss our fees. Fees are payable when services are received unless special arrangements are made in advance.

PATIENT CURRENT COMPLAINT HISTORY

Patient Name: _____ Date: _____

Please check all boxes that apply to your condition (s) and fill in the spaces that describe your **present** complaint(s). Additional information you provide concerning **past** symptoms assists the doctor understand your **total** health picture.

Please list your present complaint (s) and mark, your level of pain today for each complaint. – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ Duration – (How Long/Date): _____ # of Previous Episodes: _____
Please circle one: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ Duration – (How Long/Date): _____ # of Previous Episodes: _____
Please circle one: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ Duration – (How Long/Date): _____ # of Previous Episodes: _____
Please circle one: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? ☐ No ☐ Yes If Yes, by whom? _____

How did symptoms begin? ☐ Immediately after an incident ☐ After multiple incidents ☐ Gradually developed over time

CAUSE: _____

Are your symptoms...? ☐ Improving ☐ Getting Worse ☐ Unchanged ☐ Exacerbated ☐ Decreased ☐ Increased

Frequency of pain or symptoms:

- ☐ Constant (76-100%) ☐ Frequent (51-75%)
☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Does your pain move or radiate? ☐ Yes ☐ No
Where: _____

How many days out of an average week are you in pain?
Please circle: 1 2 3 4 5 6 7

How much time during the day are you in pain?

- ☐ Less than 1 hour ☐ 1 to 6 hours
☐ 6 to 12 hours ☐ 12 to 18 hours
☐ 18 to 24 hours ☐ 24 hours

Check the best and worse times of the day for your pain

Worse

- ☐ No Change
☐ Morning
☐ Afternoon
☐ Evening
☐ Nighttime
☐ Other: _____

Best

- ☐ No Change
☐ Morning
☐ Afternoon
☐ Evening
☐ Nighttime
☐ Other: _____

What makes your symptoms worse?

- ☐ Nothing ☐ Walking ☐ Movement ☐ Sitting
☐ Lifting ☐ Standing ☐ Driving ☐ Lying Down
☐ Other: _____

What makes your symptoms better?

- ☐ Nothing ☐ Cold ☐ Chiropractic Care
☐ Medication ☐ Movement ☐ Walking ☐ Heat
☐ Warmth ☐ TENS ☐ Standing ☐ Lying Down
☐ Other: _____

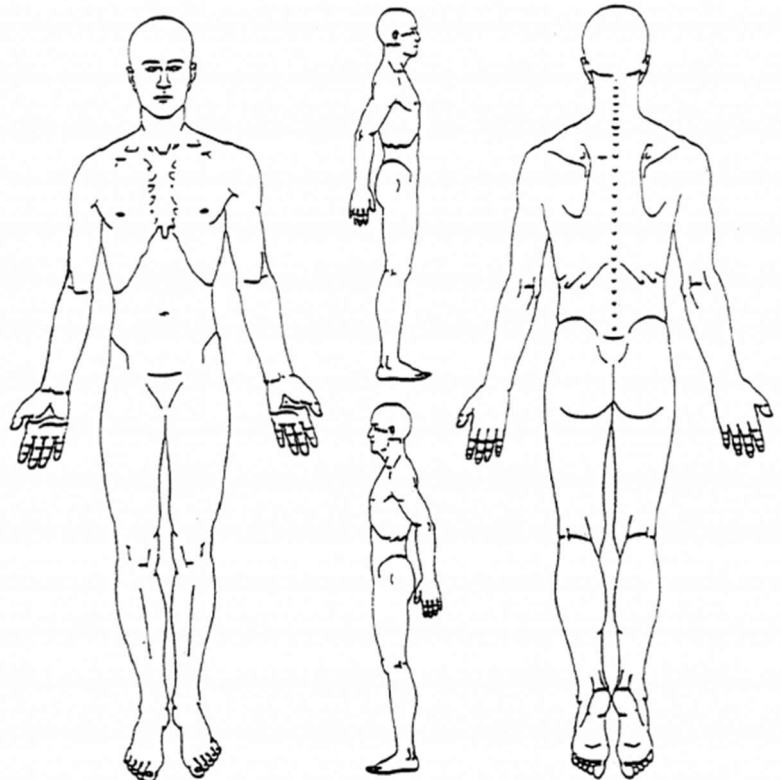
Use these symbols to mark type of pain you're experiencing

X=STIFF **A**=ACHE **D**=DULL **S**=SHOOTING

#=SHARP **N**=NUMB **T**=THROBBING **P**=TINGLING

●=SORE **W**=WEAKNESS **B**=BURNING **V**=VERTIGO

O=Other: _____



Patient's / Guardian's Signature: _____ Date: _____

SUMMIT CHIROPRACTIC HEALTH CENTER
Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance to the nervous system that occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Adjustment corrects and/or reduces subluxations, which is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Chiropractic care has been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I _____ being the parent or legal guardian of _____

Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:

(Signature)

(Date)

SUMMIT CHIROPRACTIC HEALTH CENTER

28255 N. Tatum Blvd. #106

Cave Creek, AZ 85331

480.656.0263

To assist our patients in determining if they have a third party responsible for their health expenses, we need the following information.

INSURED: _____

DOB: _____ PATIENT: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

ASSIGNMENT AUTHORIZATION, POWER OF ATTORNEY, AND AGREEMENT

In that this office is waiting for payment of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and

1. I hereby assign to this office my rights to receive payments from insurance companies. Payments should be made directly to:

Summit Chiropractic Health Center

28255 N. Tatum Blvd. #106

Cave Creek, AZ 85331

If my policy prohibits assignments, please make the check payable to me and mail to the above address.

2. I understand that if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor, agent, or attorney that will assist in the payment of a claim.
4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies and to cash any settlement draft or check. Counsel, insurance companies, and negligent parties be advised that no settlement can be effectuated without the agreement of this specific provision.
5. A photocopy of this form shall be valid as the original.

INSURED OR AUTHORIZED SIGNATURE

DATE

HIPAA: NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMIT CHIROPRACTIC HEALTH CENTER is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practice with respect to your protected health information.

Disclosure of Your Health Care Information Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Summit Chiropractic Health Center. "

"It is our policy to provide a substitute healthcare provider, authorized by Summit Chiropractic Health Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situations. "

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payments to Summit Chiropractic Health Center for health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:

"As a courtesy to our patients if you miss an appointment, it is our policy to call your home to reschedule your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment with us.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the date and time, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Summit Chiropractic Health Center's sponsored fund-raising events.

Office Practices

We may use your health information when showing gratitude for a referral by listing your name on our Referral Acknowledgement board, which hangs in the waiting room. Other patients may also view your personal health information on our daily sign in sheet.

Change of Ownership

In the event that Summit Chiropractic Health Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Summit Chiropractic Health Center is not required to agree to the restriction that you request.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon you request.
- You have the right to inspect and copy your health information.
- You have the right to request that Summit Chiropractic Health Center amend your protected health information. Please be advised, however, that Summit Chiropractic Health Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Summit Chiropractic Health Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Summit Chiropractic Health Center reserves the right to amend this Notice of Private Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Summit Chiropractic Health Center is required by law to comply with this Notice.

Summit Chiropractic Health Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact the staff at Summit Chiropractic Health Center by calling this office at (480) 656-0263.

Complaints

Complaints about your Privacy Rights, or how Summit Chiropractic Health Center has handled your health information should be directed to the staff at Summit Chiropractic Health Center by calling this office at (480) 656-0263. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building Washington, DC 20201

This notice is effective as of April 14, 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Summit Chiropractic Health Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the

Privacy Notice.

<hr/>	
Patient Name (Print)	Date
<hr/>	
Patient Signature	Date
<hr/>	
Authorized Facility Signature	Date
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