CONFIDENTIAL PATIENT INFORMATION

Your answers will help us determine if our care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case, but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

Full name:	Date:
Address: Street City State Zip	
Home phone:	Work phone:
Cell phone:	Email address:
Best time/place to contact you:	
Date of birth:	Age:
No. of children:	Pregnant? Yes ☐ No ☐
Marital status: M S W D	Spouse/Partner/Guardian name:
Occupation:	
Employer's name & address:	
Emergency contact (name/phone#):	**Will a claim be made against:** A Motor Vehicle Accident? Yes ☐ No ☐ A Work Related Injury? Yes ☐ No ☐
Name of person responsible for account:	
Social Security number:	
Who may we thank for referring you?	

Reason for Consulting Our Office:

- ☐ I have a specific health concern and require help only with this problem.
- ☐ After my specific health concern has been relieved, I am interested in strategies to ensure that it does not return.
- ☐ I have no symptoms and feel well. I am interested in strategies to help me continue to feel well, or even better.

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

How long has it been since you felt really well? _____

Other doctors you have seen for your health concerns:

"Limited Scope" Chiropractor (focuses mainly on neck & back pain)	☐
"Wellness" Chiropractor (focuses on health & well-being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (Please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?
Were x-rays taken? Yes ☐ No ☐	Was an MRI taken? Yes ☐ No ☐

Name:	Address:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?
Were x-rays taken? Yes ☐ No ☐	Was an MRI taken? Yes ☐ No ☐

Have you been "forced" of "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e. eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (please include all surgery)

1. Type:	When?	Doctor:
2. Type:	When?	Doctor:
3. Type:	When?	Doctor:
4. Type:	When?	Doctor:

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems)

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, and/or homeopathic remedies you presently take and why:

_____

_____

Diet

Please rate according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times week **FM** - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Cooked or Canned Vegetables	Dairy	Artificial Sweetener
Tobacco	Fruit	Diet food	Soda
Coffee	Fried Foods	Refined Sugar	Raw Vegetables
Organic Foods	Fasting	Grains	Other:

Past Health History

Please rate as: **O** – occasional, **F** – frequent, or **C** – constant (Mark only what applies)

O	F	C		O	F	C		O	F	C	
			GENERAL				**GASTRO-INTESTINAL**				**CARDIO-VASCULAR**
			Allergy				Belching or gas				High blood pressure
			Chills				Colitis				Low blood pressure
			Seizures				Colon trouble				Pain over heart
			Dizziness				Constipation				Slow heart beat
			Fainting				Diarrhea				Swelling of ankles
			Fatigue				Difficult digestion				**RESPIRATORY**
			Fever				Distension of abdomen				Chest pain
			Headache				Excessive hunger				Chronic cough
			Loss of sleep				Gall bladder trouble				Difficult breathing
			Loss of weight				Hemorrhoids				Spitting up blood
			Nervousness/Depression				Intestinal worms				Spitting up phlegm
			Neuralgia				Jaundice				Wheezing
			Numbness				Liver trouble				**SKIN**
			Sweats				Nausea				Boils
			Tremors				Pain over stomach				Bruise easily
			MUSCLE & JOINT				Poor appetite				Dryness
			Arthritis				Vomiting				Eczema
			Bursitis				Vomiting of blood				Hives or allergy
			Foot trouble				**EYES, EARS, NOSE, THROAT**				Itching
			Hernia				Asthma				Skin eruptions (rash)
			Low back pain				Colds				Varicose veins
			Neck pain or stiffness				Deafness				**GENITO-URINARY**
			Pain between shoulders				Dental decay				Bed-wetting
			Pain or numbness in:				Earache				Blood in urine
			Shoulders				Ear discharge				Frequent urination
			Arms				Ringing in ears				Inability to control bladder
			Elbows				Enlarged glands				Kidney infection or stones
			Hands				Thyroid problems				Painful urination
			Hips				Eye pain				Prostate trouble
			Legs				Gum trouble				Pus in urine
			Knees				Hay fever				**FOR WOMEN ONLY**
			Feet				Hoarseness				Congested breasts
			Painful tail bone				Nasal obstruction				Cramps or backache
			Poor posture				Near sightedness				Excessive menstrual flow
			Sciatica				Nosebleeds				Irregular cycle
			Spinal Curvature				Sinus infection				Menopausal symptoms
			Swollen joints				Sore throat				Miscarriage
							Tonsillitis				Painful menstruation
							Vision problems				Vaginal discharge
											ARE YOU PREGNANT? Yes ☐ No ☐

Stressors Throughout life, stressors and traumatic events can damage the spine and nervous system. These stressors are Physical, Chemical, and/or Emotional in nature. Stress affects our health and ability to heal. Please list your top three stresses (you have ever had) in each category:

1. Physical stress (birth process, falls, accidents, work postures, sports, etc.)

   _____

   _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, pesticides, etc.)

   _____

   _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

   _____

   _____

On a scale of 1-10 (1 is minimal stress & 10 is very stressful), please grade your present levels of stress (including physical, bio-chemical & psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10 (1 being very poor & 10 being excellent), please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic x-rays (if needed), and any supportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts them known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment from my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:

_____

Guardian/Parental Signature: _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Dr. Jennifer Anacker.

Please list the individual(s) with whom we are able to share your health information with, such as children, parents, or spouse.

Name:	Relationship to you:
_____	_____
_____	_____
_____	_____

Your name_____ Phone_____

The effective date of this Notice of Information Practices is _____.

Thank you.