CHIROPRACTIC
REHABILITATION CENTER

Name_____ Age_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone (Home) _____ Date of Birth_____ Sex: M F Marital Status: S M D W

Cell Phone _____ Email _____

Occupation_____ Employer_____ Phone (Work) _____

Insurance Company_____ Telephone_____

Insured's Name_____ Insured's Date of Birth_____

Insured's I.D. # _____ Group # _____

Spouse's Name_____ Spouse's Occupation_____

Spouse's Employer _____ Spouse's Phone (Work) _____

Referred by_____

Are your present problems due to an injury? ( ) Yes ( ) No
( ) On the Job ( ) Auto Accident ( ) Personal Injury ( ) Other_____

Has the accident been reported? ( ) Yes ( ) No
( ) To Employer ( ) Auto Carrier ( ) Other _____

Are you now or have you ever been disabled? (Service or Work)? ( ) Yes ( ) No If yes, when? _____

Have you retained an attorney? ( ) Yes ( ) No Name & Address _____

HEALTH REPORT:

Please describe the principal health problems for which you came to the office:_____
_____

List any other doctors seen for this:_____

List any diagnosis(es) and type of treatment(s):_____

Have you had similar accidents or injuries before? ( ) Yes ( ) No If yes, explain:_____

List the names of any relatives that have or have had a similar problem:_____

Have you or any relative received chiropractic treatment previously? ( ) Yes ( ) No
If yes, explain:_____

Have you been treated for any health condition by a physician in the last year? ( ) Yes ( ) No
If yes, explain:_____

Are you currently under medication? ( ) Yes ( ) No If so, what kind?_____

Have you been under medication in the past? ( ) Yes ( ) No If so, what kind?_____

List the approximate dates of any surgery or unusual diseases you have had:_____

_____

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Day _____
☐ Coffee Cups/Day _____

EXERCISE

☐ None
☐ Moderate
☐ Daily

Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother, # _____	☐	☐	☐	☐
Sister, # _____	☐	☐	☐	☐

Please mark each item below for each sign or symptom if you presently have or previously had:

GENERAL SYMPTOMS

☐ Convulsions
☐ Dizziness
☐ Fainting
☐ Headache
☐ Nervousness
☐ Numbness
☐ Wheezing

MUSCLES & JOINTS

☐ Low Back Problems
☐ Pain between Shoulders
☐ Neck Problems
☐ Arm Problems
☐ Leg Problems
☐ Swollen Joints
☐ Painful Joints
☐ Stiff Joints
☐ Sore Muscles
☐ Weak Muscles
☐ Walking Problems
☐ Ruptures
☐ Broken Bones

CARDIO-VASCULAR

☐ Blood Pressure Problems
☐ Pain over Heart
☐ Poor Circulation
☐ Heart Trouble
☐ Rapid Heart
☐ Slow Heart
☐ Strokes
☐ Swelling Ankles
☐ Varicose Veins

EYE/EAR/NOSE/THROAT

☐ Earache
☐ Ear Noises
☐ Enlarged Thyroid
☐ Frequent Colds
☐ Hay Fever
☐ Nasal Blockage
☐ Nose Bleeds
☐ Pain in Eyes
☐ Poor Vision
☐ Sinusitis
☐ Sore Throats
☐ Tonsillitis

GASTRO-INTESTINAL

☐ Belching/Gas
☐ Colon Trouble
☐ Constipation
☐ Diarrhea
☐ Excessive Hunger
☐ Excessive Thirst
☐ Gall Bladder Trouble
☐ Hemorrhoids
☐ Liver Trouble
☐ Nausea
☐ Pain over Stomach
☐ Poor Appetite
☐ Poor Digestion
☐ Vomiting
☐ Vomiting Blood
☐ Black Stool
☐ Bloody Stool
☐ Weight Trouble

RESPIRATORY

☐ Asthma
☐ Chronic Cough
☐ Difficulty Breathing
☐ Spitting Blood
☐ Spitting Phlegm

GENITO-URINARY

☐ Blood in Urine
☐ Frequent Urination
☐ Kidney Infection
☐ Painful Urination
☐ Prostate Trouble
☐ Bladder Trouble

SKIN OR ALLERGIES

☐ Boils
☐ Bruising Easily
☐ Dryness
☐ Eczema
☐ Hives
☐ Itching
☐ Sensitive Skin
☐ Allergy (what)

_____

FOR WOMEN ONLY

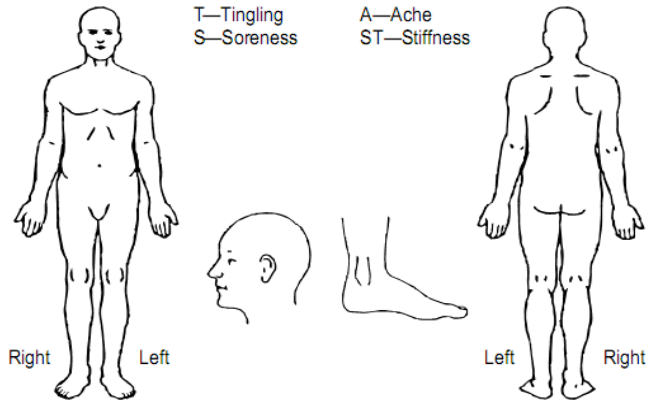
☐ Cramps/Backaches
☐ Excessive Flow
☐ Hot Flashes
☐ Irregular Cycle
☐ Miscarriage
☐ Painful Periods
☐ Vaginal Discharge
☐ Breast Pain

Pregnant at this Time
☐ Yes ☐ No

Please mark area & type of pain on the drawings using the code listed below

N—Numbness
T—Tingling
S—Soreness

P—Pain
A—Ache
ST—Stiffness



In case of emergency, please notify:

Name _____

Address _____

_____

Phone _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessa reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, I clear understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees fo professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood ar agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Th patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE **DATE**

CHIROPRACTIC
REHABILITATION CENTER

INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize it's innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and/or VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use it's innate recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

_____ _____
Signature Date

Signature_____, D.C.

CHIROPRACTIC
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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare, operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

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Patient authorization for text reminders, newsletter, emails, e-cards

It is our desire for our staff to use your name, address, email, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments or other appointment related issues. We will also use this information to possibly send birthday cards, thank you cards, health information that we feel may interest you, and/or our newsletter.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize any use of this information your decision will have no adverse effect on the care you receive or the relationship with our staff.

Please check which services you would like to opt in on. This authorization may be revoked at any time by submitting a written request.

☐ Text message reminders of upcoming scheduled appointments (standard msg rates will apply)

☐ E-cards (birthday, thank you, etc)

☐ Emails (upcoming events, promotion we may be having, etc)

☐ Newsletter

☐ Health info we think might interest you

☐ At this time I do not wish to receive any of these services

_____ _____

Signature Date

Please confirm your email address: _____

Please confirm your cell number: _____

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