Health History Form

Name: _____ Date: _____

DOB_____ Age_____ Gender: Male/Female

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email address: _____

Occupation: _____ Employer's Name: _____

Minor / Single / Married / Divorced / Separated Spouse's Name: _____

# of Children, Names, Ages & Gender _____

Who may we thank for referring you to us? _____

Main Health Concern History

Health Concerns:	Rate of Severity 0=None 10=Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

1. Please check all that apply when describing the discomfort?

□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiff □ Spasm □ Burning □ Ache □ Weak □ Numbness □ Shooting

2. Does the pain travel anywhere else? □ YES or □ NO Describe:

3. How often is this present?

□ Constant (81-100%) □ Frequent (51-80%) □ Occasional (26-50%) Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your health concern worse?

□ Nothing □ Walking □ Standing □ Sitting □ Exercise (moving) □ Lying Down □ Other

6. Have you seen anyone for your health concern? (Chiropractor, Medical Doctor, etc.) If so, who? _____

_____

7. How do your health concerns affect your daily life (brushing teeth, getting dressed, tying shoes, etc.)? _____

_____

8. Please list dates of broken bones, surgeries, or hospitalizations you have had: _____

_____

9. Please list all non-prescription, and prescription medicines, including vitamins/supplements? _____

_____

10. Please list family relation to disease history: _____

_____

11. Please list dates and type any auto accidents or major slips/falls/traumas you have been involved in: _____

_____

12. Please indicate most recent date and type of diagnostic imaging: _____

13. Spinal health is especially important during pregnancy; any chance you are pregnant? **Yes or No** (Due:_____)

Please circle all problems you have now or have had in the past:

ADD/ADHD	Ear Infections	Liver Disease	Sciatica
Allergies	Fatigue	Low Back Pain	Scoliosis
Anxiety	Fibromyalgia	Menstruation	Seizure
Asthma	Gastric Reflux	Mid Back Pain	Shoulder Pain
Blood Pressure	Headache	Migraines	Sinus
Breathing	Heart Disorder	Nausea	Sleep
Cancer	Hip Pain	Neck Pain	Stroke
Chest Pain	Infertility	Numbness in Arms	Thyroid
Diabetes	Irritable Bowel	Numbness in Hands	TMJ Disorder
Disc Problem	Kidney	Numbness in Feet	Vertigo
Digestion	Knee Pain	Numbness in Legs	Other: _____
Dizziness	Leg Pain	Rib Pain	_____

Lifestyle Exercise? □ None □ Moderate □ Daily □ Heavy

Work Activity? □ Sitting □Standing □ Light Labor □ Heavy Labor

Smoking History: **Yes or No** Packs / Day_____ Coffee / Caffeine **Yes or No** _____ Cups / Day

Alcohol: **Yes or No** Drinks / Day _____ Water Amount/Day_____

Please list your health goals: _____ _____

Indicate your commitment in helping us reach your goals; 0=None 10=Fully Committed: _____

Staff Notes_____

_____

NOTICE OF POLICIES AND PRIVACY PRACTICES ACKNOWLEDGEMENT

THIS INFORMATION IS CONFIDENTIAL. IF WE DO NOT SINCERELY BELIEVE YOUR PROBLEM WILL RESPOND FAVORABLY, WE WILL NOT BE ABLE TO ACCEPT YOUR CASE. WE WILL REFER YOU TO A HEALTH PROFESSIONAL WE BELIEVE WILL HELP YOU.

Printed Name _____ Signature _____ Date _____

INFORMED CONSENT

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 OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION. CERVICAL SPINE (NECK) ADJUSTMENTS MAY PROVOKE VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, 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 HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE. OUR FOCUS IN THIS OFFICE IS THE VERTEBRAL SUBLUXATION. HOWEVER, IF WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS, WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSES, OR TREATMENT FOR THOSE FINDINGS WE RECOMMEND THAT YOU SEEK ANOTHER HEALTHCARE PROVIDER. 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 LOCATE, ANALYZE AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC NEUROLOGICAL BASED CHIROPRACTIC ADJUSTMENTS. CHIROPRACTIC IS A VERY SPECIFIC SCIENCE, AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH CONCERNS AND NEEDS. CHIROPRACTIC IS A SEPARATE AND DISTINCT SCIENCE, ART AND PRACTICE. IT IS NOT THE PRACTICE OF MEDICINE. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION OR REGIONS OF THE SPINE WITH THE SPECIFIC INTENT OF RE-POSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE. YOUR COMPLIANCE WITH CARE PLANS, HOME AND SELF-CARE, ETC. IS ESSENTIAL TO MAXIMUM HEALING AND OPTIMAL HEALTH. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTORS ON ANY MATTER RELATED TO YOU CARE AT THIS FACILITY.

Printed Name _____ Signature_____ Date _____

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS OF PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA). I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO: 1. CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY. 2. OBTAIN PAYMENT FROM THIRD-PARTY PAYERS. 3. CONDUCT NORMAL HEALTHCARE OPERATIONS, SUCH AS QUALITY ASSESSMENTS AND PHYSICIANS' CERTIFICATIONS. I UNDERSTAND THAT I MAY REQUEST, IN WRITING, THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED TO DISCLOSE TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATION. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU AGREE, THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. ALL QUESTIONS REGARDING THE CHIROPRACTORS' OBJECTIVES TO MY CARE IN THIS OFFICE HAVE BEEN ANSWERED TO MY COMPLETE SATISFACTION. I THEREFORE ACCEPT CARE ON THIS BASIS. I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

Printed Name _____Signature_____ Date _____

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

Legal Guardian Name _____ Date_____

Relationship to Minor _____ Witness Signature (Office Staff) _____

Signature_____ Date_____

FEES: WE HAVE A ZERO-BALANCE POLICY. PAYMENT FOR SERVICES IS DUE AT THE TIME OF SERVICES RENDERED. PAYMENT OPTIONS INCLUDE CASH, CHECK, DEBIT/CREDIT CARD, AMEX, AND HSA/HRA CARDS. RETURNED CHECKS WILL BE BILLED TO THE PATIENT FOR THE AMOUNT OF THE CHECK AS WELL AS A RETURNED CHECK FEE OF $15.00. WE RESERVE THE RIGHT TO CHARGE $35 LATE FEE FOR ALL LATE PAYMENTS. CELL PHONES: AS A COURTESY TO ALL PATIENTS, PLEASE SILENCE AND REFRAIN FROM USING YOUR PHONES IN THE OFFICE. IF YOU SHOULD NEED TO TAKE A CALL, WE ASK THAT YOU PLEASE STEP OUTSIDE UNTIL THE CALL IS COMPLETE. WE THANK YOU FOR YOUR CONSIDERATION IN HELPING US TO PROVIDE A COMPLETELY RELAXING ATMOSPHERE. APPOINTMENTS: IF YOU SHOULD NEED TO RESCHEDULE AN EXISTING APPOINTMENT, PLEASE CONTACT US PRIOR TO YOUR APPOINTMENT TIME SO THAT WE ARE BETTER ABLE TO FIND A TIME THAT WORKS FOR YOU. WE ASK THAT YOU PLEASE PROVIDE US WITH 24-HOUR NOTICE FOR ANY APPOINTMENT CANCELLATIONS; THIS OFFICE RESERVES THE RIGHT TO CHARGE $25.00 FOR ANY NO CALL, NO SHOW MISSED APPOINTMENTS. MULTIPLE DOCTOR CARE: AT ANY GIVEN TIME, YOU MAY BE ADJUSTED BY ANYONE OF OUR QUALIFIED DOCTORS. IF YOU PREFER A SPECIFIC DOCTOR, SCHEDULE ACCORDINGLY AT THE FRONT DESK. REFERRALS: WE ASK THAT YOU CONSIDER US FOR REFERRALS TO YOUR FRIENDS/FAMILY. IT IS IMPORTANT TO US TO DELIVER THE MESSAGE OF TRUE HEALTH TO THE COMMUNITY AND WE ASK FOR YOUR HELP IN DOING SO.

I have read the above and I understand and accept these policies.

Patient's Signature_____ Date_____