# Health History

FOUNDATION CHIROPRACTIC

Today's Date: _____

## PERSONAL DATA

Name: _____ Preferred Name: _____ Date of Birth: _____
Both Parent's names: (if you're under 18) _____
Address: _____ City: _____State/Zip: _____
Cell Phone: (_____) _____ Secondary Phone: (_____) _____
E-mail address: _____
Occupation: _____ Employer: _____
Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse/Partner's Name: _____
Names & Ages of Children: _____
Whom may we thank for referring you to our office? _____

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Foundation Chiropractic can address for you?

_____

_____

Are these concerns affecting your quality of life?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Work: | ☐ Y | ☐ N | Driving: | ☐ Y | ☐ N | Sleep: | ☐ Y | ☐ N |
| School: | ☐ Y | ☐ N | Walking: | ☐ Y | ☐ N | Sitting: | ☐ Y | ☐ N |
| Exercise/Sports: | ☐ Y | ☐ N | Eating: | ☐ Y | ☐ N | Love Life: | ☐ Y | ☐ N |

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? ☐ Y ☐ N Name of D.C. _____
How long under care? ☐ _____ days ☐ _____ weeks ☐ _____ months ☐ _____ years
Date of last visit: _____ Why did you stop care? _____

Have you consulted or do you regularly consult any of the providers below? *(check all that apply)*

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ OT/PT
☐ Massage Therapist ☐ Psychotherapist ☐ Dentist ☐ Other

Reason: _____

## FOR WOMEN

Are you pregnant? ☐ Y ☐ N Date of last menstrual period: _____
If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.
Signature: _____ Date: _____
If pregnant, Due Date:_____ Name of Midwife or OBGYN: _____
Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center

# Health, Vitality, & Chiropractic Care

The primary system in the body which coordinates health is the **nerve system**. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life and how they may be related to your present spinal, nerve and health status and whether they may have caused vertebral subluxations to occur.

## PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.

Please check where and how you were birthed. *(If you do not know, please skip to next question)*

| | | | | |
|---|---|---|---|---|
| ☐ Home | ☐ Natural | ☐ Hospital | ☐ Caesarian section | ☐ Forceps |
| ☐ Breech | ☐ Cord around neck | ☐ Prolonged labor | ☐ Drug induced labor | ☐ Suction |

## PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? *(Check all that apply)*

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse

If yes, state the type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ☐ Y ☐ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ☐ Y ☐ N

If yes, state reason and dates: _____

## EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

| | | | | | |
|---|---|---|---|---|---|
| Childhood Trauma | ☐ Y ☐ N | Loss of loved one | ☐ Y ☐ N | Abuse | ☐ Y ☐ N |
| Work or School | ☐ Y ☐ N | Divorce/separation | ☐ Y ☐ N | Financial | ☐ Y ☐ N |
| Lifestyle change | ☐ Y ☐ N | Parents' divorce | ☐ Y ☐ N | Illness | ☐ Y ☐ N |

## CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ☐ Y ☐ N If yes, did you have a reaction? ☐ Y ☐ N ☐ Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

☐ Toxic chemicals ☐ Secondhand smoke ☐ Drug therapy
☐ Radiation Therapy ☐ Chemotherapy ☐ Other

If yes, please list: _____

Do you have allergies or sensitivities to any foods? ☐ Y ☐ N

If yes, please list: _____

Do you presently consume any of the following?

☐ Coffee/caffeine ☐ Alcohol ☐ Tobacco ☐ Over the counter drugs ☐ Prescribed drugs

Please list all medications (prescribed and over the counter): _____

_____

_____

## QUALITY OF LIFE (presently)

How do you grade your physical health? ☐ Good ☐ Fair ☐ Poor

How do you grade your emotional/mental health? ☐ Good ☐ Fair ☐ Poor

How do you rate your overall "quality of life"? ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

## YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: *(Check all that apply)*

☐ Symptomatic relief of a problem
☐ Prevention of future problems
☐ Healthier spine and nerve system
☐ Optimal health on all levels
☐ Other: _____

# Finances

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Payment in full is expected on all FIRST VISIT services.

First Visit Fees: Comprehensive Exam: $200 (Ages 13+) | Prenatal Exam: $150 | Child Exam $75 (Ages 0-12)

Please indicate your method of payment: ☐ Cash ☐ Check ☐ Credit Card ☐ HSA ☐ FSA

## Our Approach to Finances at Foundation Chiropractic

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation) at affordable fees.

## Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with *itemized statements for you to submit upon request*.

## Have you had an Auto Accident, a Worker's Compensation Injury or a Personal Injury?

If yes, please provide us with the following information:

Date of Injury: _____ Have you been treated for injuries? ☐ Yes ☐ No

If yes, where? ☐ Emergency Room ☐ Primary Care ☐ Chiropractor

What services were provided? ☐ MRI ☐ X-Rays ☐ Medication ☐ Therapy

*NOTE: You may be required to pay for all services until we receive approval and payment from the insurance carrier.*

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give the doctors at Foundation Chiropractic permission to render care to me today.

Name (printed): _____ Date: _____

Signature: _____

Signature of Parent (for minor): _____

ChiroFutures

**Informed Consent**

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

**Chiropractic** is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship

**Initials:**

between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE FOUNDATION CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.**
**DATED THIS ___ DAY OF _____, 20__**

_____ _____

**Patient Signature** **Doctor's Signature**

**Parental Consent for Minor Patient:**

Patient Name: _____

Patient age: _____ DOB: _____

**Printed name of person legally authorized to sign for:**

Patient: _____

Signature: _____

Relationship to Patient: _____

**In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.**

**Printed name of person legally authorized to sign for:**

Patient: _____

Signature: _____

Relationship to Patient: _____

**Remarks:**

FOUNDATION
CHIROPRACTIC

*907 Honea Egypt Road, Magnolia, TX 77354*
*832-458-3004*

# HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Foundation Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

**SPECIFIC AUTHORIZATIONS:**

- I give permission to Foundation Chiropractic to use my email address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Foundation Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Foundation Chiropractic to use my name on a welcome board, referral board, and birthday board.
- I give permission to Foundation Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website, and ads in print media.
- I give permission to Foundation Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give Foundation Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Foundation Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Foundation Chiropractic plus 7 years or until revoked by me.

**Initials:**

**RIGHT TO REVOKE AUTHORIZATION:**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Foundation Chiropractic (Dr. Evan Pulver).
The written notice must contain the following information:

- Your name
- Date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Foundation Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION,

Foundation Chiropractic will not refuse to provide treatment however, it will not be possible for Foundation Chiropractic to respond to third party billing on my behalf and I will be responsible for 1) scheduling my own appointments since Foundation Chiropractic will be unable to contact me 2) all contact with Foundation Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

## HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Date of Birth: _____

Patient's Name (please print): _____

Patient's Signature: _____

Today's Date: _____

**Name of Personal Representative (if someone is designated to act on your behalf/or for a minor):**

Parent or Personal Representative name (please print):

Signature:

Description of Representative's Authority to Act on Patient's Behalf:

_____