Patient # _____

CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

PATENT DATA

Today's Date (MM/DD/YYYY)

Last Name | First Name | Middle Initial | Nick Name | Gender O Male O Female

Address | City | State | Zip

Birth Date (MM/DD/ICY) | Age | Email Address

Preferred Method of contact?
O Home Phone O Cell Phone
O Work Phone O Email
O Text Message- Reminders

Home Phone | Cell Phone | Work Phone

Occupation | Employer Name

Is it ok to call you at work?
O Yes O No

Employer Address | City | State | Zip

SPOUSE & FAMILY DATA

Marital Status: O Single O Married O Divorced O Widowed O Separated

Spouse's Name | Spouse's Birth Date | Cell Phone | Work Phone

Child's Name and Age | Child's Name and Age | Child's Name and Age

INCASE OF EMERGENCY

Emergency Contact | Phone Number | Relationship

Have you considered a chiropractor before?
O No O Yes

Whom may we thank for referring you? | When? | If so, whom?

CONFIDENTIAL INSURANCE INFORMATION

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
O Self O Spouse O Parent

Insured's Employer | Employer's Phone

Employer Address | City | State | Zip

Do you have a Secondary Insurance as well? O No O Yes If so, list the Insurance Carrier: _____

Patient # _____

PURPOSE OF THIS VISIT

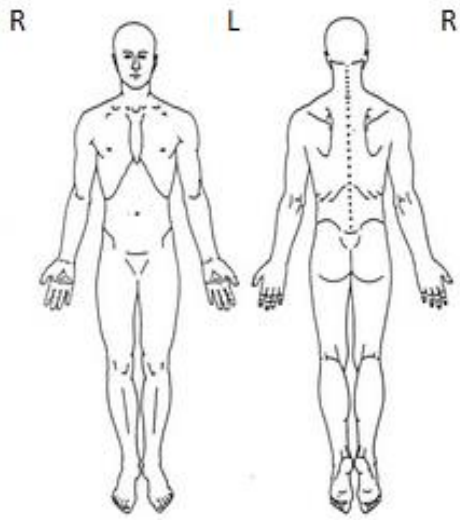
1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the results of: (darken circle) O An accident or injury: O Work O Auto O Other: _____
   O A worsening long-term problem O An interest in: O Wellness O Other: _____
3. Onset: (When did you first notice your current symptoms?) _____
4. Intensity: (How extreme are your current symptoms at their **WORST** & on **AVERAGE**?)

Headache:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE**:	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Neck Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE**:	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Mid Back Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE**:	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Low Back Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE**:	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Other:_____	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE**:	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme

5. Location: (Where does it hurt?) Circle the area(s) on the illustration.



6. Radiation: (Does it affect other areas of your body? Does the pain radiate, shoot or travel?)

_____

*With Questions 7-11, please circle **H** for Headache, **N** for Neck, **M** for Mid Back, **L** for Low Back, and **O** for Other*

7. Duration & Timing: (When did it start and how often did you feel it?) _____

   H N M L O Constant- 76% to 100% of day H N M L O Frequent- 51% to 75% of day

   H N M L O Occasional - 26 to 50% of day H N M L O Intermittent - 0% to 25% of day

   Are your symptoms worse in the morning, afternoon, or evening? Yes / No _____

8. Quality of symptoms: (What does it feel like?)

H N M L O Dull	H N M L O Stabbing	H N M L O Burning	H N M L O Radiating
H N M L O Tingling	H N M L O Throbbing	H N M L O Numbness	H N M L O Aching
H N M L O Sharp	H N M L O Cramps	H N M L O Deep	H N M L O Stiffness
H N M L O Other: _____		H N M L O Other: _____	

9. Aggravating Factors: (What makes it worse?)

H N M L O Sitting	H N M L O Sleeping	H N M L O Looking up	H N M L O Typing
H N M L O Lifting	H N M L O Twisting	H N M L O Driving	H N M L O Stair Stepping
H N M L O Reaching	H N M L O Lying Face Up	H N M L O Lying Face Down	H N M L O Sit to Stand
H N M L O Rest	H N M L O Exercise	H N M L O Bending	H N M L O Straining
H N M L O House Chores	H N M L O Walking	H N M L O Coughing	H N M L O Movement
H N M L O Standing	H N M L O Sneezing	H N M L O Looking down	H N M L O Scooping
H N M L O Other: _____		H N M L O Other: _____	

10. Relieving Factors: (What makes it feel better ?)

H N M L O Sitting	H N M L O Standing	H N M L O Lying	H N M L O Knees Bent Up	H N M L O Support
H N M L O No Movement	H N M L O Heat	H N M L O Ice	H N M L O Analgesic Topical: ie: Biofreeze, Bengay, Icy Hot	
H N M L O Ibuprofen	H N M L O Medication	H N M L O Rest	H N M L O Stretching/Exercise	H N M L O Adjustments
H N M L O Massage	H N M L O Other: _____		H N M L O Other: _____	

11. Prior Interventions: (What have you done to relieve the symptoms?)

H N M L O Prescription Medication	H N M L O Physical Therapy	H N M L O Ice	H N M L O Drugs	H N M L O Acupuncture
H N M L O Over-the-Counter	H N M L O Chiropractic	H N M L O Heat	H N M L O Massage	
H N M L O Homeopathic Remedies	H N M L O Surgery	H N M L O Other: _____	H N M L O Other: _____	

12. What else should Dr. Amy Nedrow know about your current condition? _____

_____

13. How does your current condition interfere with your:

    Work or Career: _____

    Recreational Activities: _____

    Household Responsibilities: _____

    Personal Relationships: _____

Consultation Notes:

Reviewed with the patient on _____/_____/_____. _____

MEDICAL CARE INFORMATION

14. Review of Symptoms:

Chiropractic care focuses on the integrity of your nervous system, which controls and regulated your entire body.
Please darken the circle beside any condition that you've **HAD** or currently **HAVE** and initial to the right.

a. Musculoskeletal:

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Osteoporosis	O	O	Arthritis	O	O	Scoliosis	O	O	Foot/Ankle Pain	O	O	Back Problems
O	O	Hip Disorders	O	O	Knee Injuries	O	O	Neck Pain	O	O	Shoulder Problem	O	O	Elbow/Wrist Pain
O	O	TMJ Issues	O	O	Poor Posture		O	**None**						

b. Neurological: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anxiety	O	O	Depression	O	O	Headache	O	O	Dizziness	O	O	Pins and Needles
O	O	Numbness		O	**None**									

c. Cardiovascular: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	High Blood Pressure	O	O	High Cholesterol	O	O	Angina	O	O	Excessive Bruising	O	O	Poor Circulation
O	O	Low Blood Pressure		O	**None**									

d. Respiratory: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Asthma	O	O	Apnea	O	O	Emphysema	O	O	Shortness of Breath	O	O	Hay fever
O	O	Pneumonia		O	**None**									

e. Digestive: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anorexia	O	O	Bulimia	O	O	Ulcer	O	O	Food Sensitivities	O	O	Heartburn
O	O	Constipation	O	O	Diarrhea	O	O	Loss of Bowel		O	**None**			

f. Sensory: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Loss of Smell	O	O	Hearing Loss	O	O	Blurred Vision	O	O	Chronic Ear Infection	O	O	Ringing in Ears
O	O	Loss of Taste		O	**None**									

g. Integumentary: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Skin Cancer	O	O	Psoriasis	O	O	Eczema	O	O	Acne	O	O	Hair Loss
O	O	Rash		O	**None**									

h. Endocrine: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Immune Disorders	O	O	Thyroid Issue	O	O	Hypoglycemia	O	O	Swollen Glands	O	O	Frequent Infection
O	O	Low Energy		O	**None**									

i. Genitourinary: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Kidney Stones	O	O	Infertility	O	O	Bedwetting	O	O	Erectile Dysfunction	O	O	Prostate Issues
O	O	PMS Symptoms	O	O	Loss of Bladder		O	**None**						

j. Constitutional: ***Initials**

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Fainting	O	O	Low Libido	O	O	Poor Appetite	O	O	Sudden Weight Gain	O	O	Sudden Weight Loss
O	O	Fatigue	O	O	Weakness		O	**None**						

***Initials**

PAST PERSONAL HISTORY

Office use only: O All other Systems are Negative

Please identify your past history, including injuries, illnesses, and treatments. Please complete each section fully.

15. Illnesses: Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have		Had	Have		Had	Have		O Other:
O	O	Aids	O	O	Diabetes	O	O	Malaria	O	O	Scarlet Fever	_____
O	O	Alcoholism	O	O	Epilepsy	O	O	Measles	O	O	STD's	_____
O	O	Allergies	O	O	Glaucoma	O	O	Multiple Sclerosis	O	O	Stroke	_____
O	O	Arteriosclerosis	O	O	Heart Disease	O	O	Mumps	O	O	Tuberculosis	_____
O	O	Cancer	O	O	Hepatitis	O	O	Polio	O	O	Typhoid Fever	_____
O	O	Chicken Pox	O	O	HIV Positive	O	O	Rheumatic Fever	O	O	Ulcer	

Consultation Notes:

Reviewed with the patient on _____/_____/_____. _____

16. Operations: Surgical interventions, which may or may not have included hospitalization.

	When?		When?		When?
O Appendix Removal	_____	O Hysterectomy	_____	O Tonsillectomy	_____
O Bypass Surgery	_____	O Pacemaker	_____	O Vasectomy	_____
O Cancer:_____	_____	O Spine:_____	_____	O Other:_____	_____
O Eye Surgery	_____	O _____	_____	_____	_____
O Gallbladder Surgery	_____	O _____	_____	_____	_____

17. Treatments: Check the ones you've received in the **PAST** or are receiving **CURRENTLY**.

Past	Current		Past	Current	
O	O	Acupuncture	O	O	Herbs
O	O	Antibiotics	O	O	Homeopathy
O	O	Birth Control Pills	O	O	Hormone Replacement
O	O	Blood Transfusions	O	O	Inhaler
O	O	Chemotherapy	O	O	Massage Therapy
O	O	Dialysis	O	O	Physical Therapy

Medication Name:	Dosage:	Times/Day:	Condition:

18. Injuries: Have you ever…

O Had a spine or nerve disorder
O Been injured in an accident
O Been knocked unconscious
O Used a neck or back bracing
O Used a crutch or other support
O Had a fractured or broken bone
O Received a tattoo
O Had a body piercing
O Been in a Motor Vehicle Accident
How many: ___ Dates: _____
Did you seek care for your injuries? Y N

FAMILY HISTORY

19. Some health issues are hereditary. Please tell Dr. Amy Nedrow about the health of your immediate family members.

Relative	Age (If Living)	State of Heath: Good	State of Heath: Poor	Illnesses	Age at Death	Cause of death: Natural	Cause of death: Illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sibling 1: S / B	_____	O	O	_____	_____	O	O
Sibling 2: S / B	_____	O	O	_____	_____	O	O
Sibling 3: S / B	_____	O	O	_____	_____	O	O

20. Are there any other hereditary health issues that you know about? _____

SOCIAL HISTORY

21. Please tell Dr. Amy Nedrow about your health habits and stress levels.
Height _____ft ____in Current Weight: _____lbs
Write with: R hand / L hand / Ambidextrous

Exercise	O Daily	O Weekly	Hours? _____Type?_____
Alcohol Consumption	O Daily	O Weekly	How much?_____
Tobacco Use	O Daily	O Weekly	How much?_____
	O Never Smoked	O Former Smoker	O Interested in Quitting? O Yes O No
Coffee Consumption	O Daily	O Weekly	Cups?_____
Soft Drinks	O Daily	O Weekly	Glasses?_____
Water Intake	O Daily	O Weekly	Ounces?_____
Pain Relievers	O Daily	O Weekly	How much & Type?_____

Physical Stress?	O Yes O No	Mercury Fillings?	O Yes O No
Emotional Stress?	O Yes O No	Recreational Drug Use?	O Yes O No
Major Stressors:	O Yes O No	Wear a Seatbelt?	O Yes O No

Hour of Sleep per Night? ___ Favorite Sleeping Position? O Back O Stomach O Side L /R

Type and Age of Mattress? _____

Typical Eating Habits O Skip breakfast O Two Meals/Day O Three Meals/Day O Snacking Between Meals

23. Is there anything else that you can no longer do because of the pain you are in? O Yes O No
Please Explain: _____

26. In addition to the main reason for your visit today, what additional health goals do you have? _____

22. Activities of Daily Living: How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising out of Chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying Down	O	O	O	O
Bending Over	O	O	O	O
Climbing Stairs	O	O	O	O
Using a Computer	O	O	O	O
Getting In/Out of Car	O	O	O	O
Driving a Car	O	O	O	O
Looking over Shoulder	O	O	O	O
Caring for Family	O	O	O	O
Grocery Shopping	O	O	O	O
Household Chores	O	O	O	O
Lifting Objects	O	O	O	O
Reaching Overhead	O	O	O	O
Showering or Bathing	O	O	O	O
Dressing Myself	O	O	O	O
Love Life	O	O	O	O
Getting to Sleep	O	O	O	O
Staying Asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard Work	O	O	O	O

Consultation Notes:

Reviewed with the patient on _____/_____/_____. _____

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I do herby give my consent to allow Contour Chiropractic and its representatives, as deemed necessary by the examining physician to take radiographs of my spine and/or extremities.

Initials _____ ***Females Only**: I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's first name: _____

_____ _____

Signature Date (MM/DD/YYYY)

HEALTHCARE AUTHORIZATION FORM

HIPAA Required Form

THE FOLLOWING AUTHORIZES CONTOUR CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

I grant permission 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 assures that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

I grant permission to Contour Chiropractic to be called or to be sent a text message to confirm or reschedule an appointment. I also grant permission to use my name, address, phone number and clinical records to contact me with recall postcards, thank you cards, welcome cards, birthday cards, holiday related cards, health related e-mail messages, reminder text messages, and information about treatment alternatives or other health related information as well as any advertisements, newsletters, or patient of the week/month postings as an extension of my care in this office.

I grant permission to Contour Chiropractic 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 protective health care information during the course of my treatment. Should I need to speak with a doctor or chiropractic assistant in private, the doctor or assistant will provide a private room for these conversations.

A patient's written consent need only be obtain a one time for all subsequent care given the patient in this office.

If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I _____ have read and understand how my Patient Health Information will be used and I agree to these policies and procedures, I also understand that I have the following rights and privileges:

* The right to object to the use of my health care information for directory purposes
* The right to request to know what disclosures have been made and submit in writing any further restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations. Our office is not obligated to agree to those restrictions.
* The right to examine and obtain a copy of my health records at any time and request corrections.

_____ _____ _____

Signature **Print Name** **Date**

Signed form received by: _____ Date: _____

Contour Chiropractic

Dedicated to Quality Care

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The practice of Chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating *vertebral subluxations. A vertebral subluxation is a* misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's natural ability to express its maximum potential.

2. *Adjustments* of the spine for the purpose of correcting *vertebral subluxations*. An *adjustment* is the specific application of forces to facilitate the body's correction of *vertebral subluxation*. Our chiropractic method of correction is by specific *adjustments* of the spine.

3. Education and encouragement of our practice members to become aware of and be responsible for their own *health* and well-being. *Health* is a state of optimal physical, mental and social well being, not merely the absence of disease and infirmity.

4. Empowerment of our practice members regarding the inherent healing capabilities of the human body.

Your care in the office is not a substitute or alternative for, nor is it a preventative form of medicine. No statement of the chiropractor is intended as a medical diagnosis and should not be confused as such. Regardless of what the disease is called, we do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Patient's Signature Date

_____ _____

Minor: (signature of parent or guardian if minor) Date