# CONFIDENTIAL
# HEALTH INFORMATION

**All information you supply is confidential.**
**We comply with all federal privacy standards.**
**Please print clearly.**

**Today's Date (MM/DD/YYYY)**

**Have you consulted a chiropractor before?**

◯ No ◯ Yes

**Whom may we thank for referring you?**

**When?**

**If so, whom?**

**Age**

**Gender**
◯ Male ◯ Female ◯ Other

**Primary Care Provider's Name**

**Birth Date (MM/DD/YYYY)**

**Marital Status**
◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

**Your Last Name**

**Your First Name** **Middle Name (initial)**

**Spouse's Name**

**Address**

**Child's Name and Age**

**City** **State/Province** **Zip Code**

**Child's Name and Age**

**Home Phone** **Cell Phone**

**Child's Name and Age**

**Email Address**

**Child's Name and Age**

**Emergency Contact** **Emergency Contact Phone**

**Emergency Contact Relationship to Patient**

**Your Employer**

**Work Phone**

**Address**

**May we contact you at work?**
◯ No ◯ Yes

**City** **State/Province** **Zip Code**

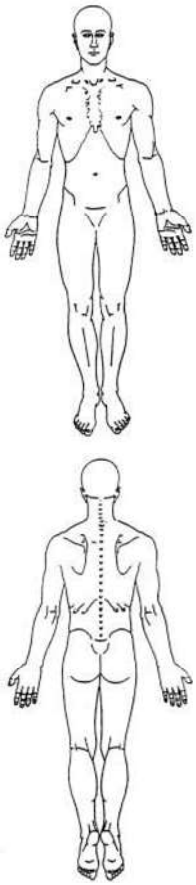
**Preferred method of contact?**
◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

**CONFIDENTIAL HEALTH INFORMATION**

**Sacred Touch Chiropractic**
**Dawn Tames, D.C.**
10615 North Hayden Road Suite C106 • Scottsdale, Arizona 85260 • 480-315-8444

**Please describe your Primary Complaint in the space below.**
**Use the Secondary and Additional Complaint boxes if they apply.**

**Location**
(Where does it hurt?)
Mark the area(s) on the illustration.
"O" for current condition
"X" for past condition



| **Primary Complaint**<br>The primary symptom that prompted me to seek care today is: | **Secondary Complaint**<br>The secondary symptom that prompted me to seek care today is: | **Additional Complaint**<br>The additional symptom that prompted me to seek care today is: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| **And are the result of:**<br>(darken circle)<br>◯ An accident or injury<br>◯ Work ◯ Auto ◯ Other | **And are the result of:**<br>(darken circle)<br>◯ An accident or injury<br>◯ Work ◯ Auto ◯ Other | **And are the result of:**<br>(darken circle)<br>◯ An accident or injury<br>◯ Work ◯ Auto ◯ Other |
| ◯ A worsening long-term problem | ◯ A worsening long-term problem | ◯ A worsening long-term problem |
| ◯ An interest in:<br>◯ Wellness ◯ Other _____ | ◯ An interest in:<br>◯ Wellness ◯ Other _____ | ◯ An interest in:<br>◯ Wellness ◯ Other _____ |
| **Onset** (When did you first notice your current symptoms?) | **Onset** (When did you first notice your current symptoms?) | **Onset** (When did you first notice your current symptoms?) |
| **Prior interventions** (What have you done to relieve the symptoms?)<br>◯ Prescription medication<br>◯ Over-the-counter drugs<br>◯ Acupuncture<br>◯ Homeopathic remedies<br>◯ Massage<br>◯ Physical Therapy<br>◯ Ice<br>◯ Heat<br>◯ Surgery<br>◯ Other_____ | **Prior interventions** (What have you done to relieve the symptoms?)<br>◯ Prescription medication<br>◯ Over-the-counter drugs<br>◯ Acupuncture<br>◯ Homeopathic remedies<br>◯ Massage<br>◯ Physical Therapy<br>◯ Ice<br>◯ Heat<br>◯ Surgery<br>◯ Other_____ | **Prior interventions** (What have you done to relieve the symptoms?)<br>◯ Prescription medication<br>◯ Over-the-counter drugs<br>◯ Acupuncture<br>◯ Homeopathic remedies<br>◯ Massage<br>◯ Physical Therapy<br>◯ Ice<br>◯ Heat<br>◯ Surgery<br>◯ Other _____ |

**What else should Dr. Dawn know about your current health condition?**

**How does your current condition interfere with your:**

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

**Any other health issues?** _____

## Past Personal and Family History

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

### Illnesses

Check the illnesses you have **HAD** in the past or **HAVE** now.

| Had | Have | |
|---|---|---|
| ◯ | ◯ | AIDS |
| ◯ | ◯ | Alcoholism |
| ◯ | ◯ | Allergies |
| ◯ | ◯ | Arteriosclerosis |
| ◯ | ◯ | Cancer |
| ◯ | ◯ | Chicken Pox |
| ◯ | ◯ | Diabetes |
| ◯ | ◯ | Epilepsy |
| ◯ | ◯ | Glaucoma |
| ◯ | ◯ | Goiter |
| ◯ | ◯ | Gout |
| ◯ | ◯ | Heart Disease |
| ◯ | ◯ | Hepatitis |
| ◯ | ◯ | HIV Positive |
| ◯ | ◯ | Malaria |
| ◯ | ◯ | Measles |
| ◯ | ◯ | Multiple Sclerosis |
| ◯ | ◯ | Mumps |
| ◯ | ◯ | Polio |
| ◯ | ◯ | Rheumatic Fever |
| ◯ | ◯ | Scarlet Fever |
| ◯ | ◯ | Sexually Transmitted Disease |
| ◯ | ◯ | Stroke |

| Had | Have | |
|---|---|---|
| ◯ | ◯ | Tuberculosis |
| ◯ | ◯ | Typhoid Fever |
| ◯ | ◯ | Ulcer |
| ◯ | ◯ | Other: _____ |

### Allergies

Are you allergic to any medications?

**Yes No**

◯ ◯ If Yes please list: _____

### Injuries

Have you ever...

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

### Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix Removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery:
- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine _____
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: _____

### Medications

Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals you take.

_____

_____

_____

_____

### Treatments

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

| Past | Currently | |
|---|---|---|
| ◯ | ◯ | Acupuncture |
| ◯ | ◯ | Antibiotics |
| ◯ | ◯ | Birth control pills |
| ◯ | ◯ | Blood transfusions |
| ◯ | ◯ | Chemotherapy |
| ◯ | ◯ | Chiropractic care |
| ◯ | ◯ | Dialysis |
| ◯ | ◯ | Herbs |
| ◯ | ◯ | Homeopathy |
| ◯ | ◯ | Hormone replacement |
| ◯ | ◯ | Inhaler |
| ◯ | ◯ | Massage therapy |
| ◯ | ◯ | Physical Therapy |

### Family History

Some health issues are hereditary. Tell Dr. Dawn about the health of your immediate family members.

| Relative | Age (If living) | State of health: Good | State of health: Poor | Illnesses | Age at death | Cause of death: Natural | Cause of death: Illness |
|---|---|---|---|---|---|---|---|
| Mother | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |
| Father | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |
| Sister 1 | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |
| Sister 2 | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |
| Brother 1 | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |
| Brother 2 | _____ | ◯ | ◯ | _____ | _____ | ◯ | ◯ |

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

_____

**What is the major stressor in your life?** _____

_____

**How much sleep do you average per night?_____Hours**

**What is the type and approximate age of your mattress and pillow?** _____

**What is your preferred sleeping position?** _____

**Describe your typical eating habits:** ◯ Skip breakfast ◯ 2 meals a day ◯ 3 meals a day ◯ Snacking between meals

**What would be the most significant thing you could do to improve your health?** _____

_____

**In addition to the main reason for your visit today, what other health goals do you have?** _____

_____

_____

**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 may request a copy of the Privacy Policy and understand it describes how my personal health information is protected.**

_____ Initials **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:** _____

_____ Initials **I grant permission to be called to confirm or reschedule an appointment, and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.**

_____ 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 concerns.**

_____ _____

Patient/Guardian Signature Date

# CHIROPRACTIC WELLNESS CARE

In order for us to be able to better serve you, we would like you to understand what will take place during care with us. Our Mission is to educate and adjust as many families as possible toward optimal health through natural and unique chiropractic care.

**New Patient Visit** - your first visit will consist of a one-hour in-depth consultation, which will include x-rays (for non-pregnant patients). You will get an adjustment and traction if appropriate. Our initial consultation is **$150.00**.

When X-rays are taken, we will also go over your solution report. You will receive a copy of this solution report for your records. Due to the seriousness of this report, your spouse, or the person who helps you with your health and financial decisions, we suggest to be present. We have this policy so you will have support in making this most important health care decision and for you to thoroughly understand your condition and how we can help you. We look forward to working with you.

**Welcome to our chiropractic family**!

_____ We at Sacred Touch Chiropractic (STC) understand that situations may arise that requires you to cancel your appointment; however, we do require a 24-hour notice of such cancellation. We may charge a **$65.00** fee or **apply the visit to your care plan**, for any appointments that have not been cancelled within this time frame.

_____ Our Mindbody software does retain your cc information securely. If there is a payment that is owed such as a no-show or care plan payment, we will charge your card for the amount due.

_____ We have created care plans based on your commitment of achieving and maintaining your wellness. Please review our Wellness Care Plans and let us know which plan is best for you. We offer AutoPay to assist you with your payments.

_____ We are happy to supply you with a copy of your medical records; however, this service is subject to a **$25.00 processing fee**. We require patients to complete a Medical Release form. After the form is completed and the fee is paid, please give our staff up to 7 business days to get these records together. We can fax medical records through a secure fax line to another medical provider.

_____ If you stop your treatment plan for longer than 90 days your Care Plan is void and the Standard Visit fee will be charged. If you resume your care after the 90 days there will be a **$65.00 Returning Patient fee** before reinstating your Care Plan. **If you have not seen longer than 3 years, this plan will be no longer valid.**

_____ Payment is due at time of visit. Sacred Touch Chiropractic is willing to work with you on a payment plan. **All payment plans need to be on Auto Pay.** We will assign all accounts (30) days or more past due to an outside collection agency. This may be an automatic assignment unless management has approved prior arrangements.

Patient Signature: _____ Date: _____

Patient Name: _____

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# DOCTOR – PATIENT RELATIONSHIP IN CHIROPRACTIC

## Chiropractic

Chiropractic is a health care discipline, which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

## Analysis

A Chiropractor conducts a clinical analysis for the express purpose of determining whether there is evidence of *Vertebral Subluxation Complexes (VSC).* When such complexes 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 its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of your own body.

## Diagnosis

Chiropractors are experts in diagnosing the Vertebral Subluxation Complex but are not internal medical specialist. Every Chiropractic patient should be mindful of his/her own symptoms and express any change in their condition to their physician. Together the patient and physician can evaluate the situation and determine an appropriate course of action. The chiropractor, being a primary health care provider has a network with other health care professionals and if warranted may advise a referral. The STC patient is ultimately responsible for his or her own health care.

## Informed Consent for Chiropractic Care

A patient, in coming to the chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis, and analysis. The chiropractic adjustment and 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 is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the Chiropractor. The patient should look to the correct specialist for the proper diagnosis and procedures. The Chiropractor 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 health care regime.

## Results

The purpose of Chiropractic services is to promote natural healing through the reduction of the Vertebral Subluxation Complex. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but 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 with Chiropractic care. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control of 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 achieved great strides in alleviating pain and controlling disease.

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**Chiropractic doctors do not treat disease; they adjust subluxations to remove nerve interference, thus allowing the body to improve its function and heal itself.**

All questions regarding the doctor's objective pertaining to my care, in this office, have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

**HIPPA Laws**

Due to HIPPA Laws – Please refrain from talking on your cell phone in this office. No picture taking allowed.

**Photograph/Video Release**

_____ I give my permission for Dr. Dawn Tames/Sacred Touch Chiropractic to use my (and my children(s)) photographs described as "Single Still Photographs" for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content on Sacred Touch Chiropractic / Dr. Dawn Tames marketing material and social networking sites (website, Instagram, Facebook, Yelp, etc). These photographs will be used exclusively for that purpose and will not be shared with anyone else I have the right to have my photograph taken off the website at any time upon my written request. Furthermore, I understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

**Credit Card Authorization**

_____ I understand and authorize that my credit/debit card will be on file. If I have an outstanding balance this credit/debit card will be used for those fees. I may cancel this authorization at any time.

**Patient Name:** _____

**Patient Signature:** _____ **Date:** _____

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