

About the Patient

Name _____

Date of Birth (month/day/year) ____/____/____ Age ____ Gender: M / F

Marital Status: Married Life Partners Single Divorced Widowed

Address _____

City _____ State _____ Zip _____

Primary Phone (____) _____ - _____ Secondary/Work Phone (____) _____ - _____

Type of Work/Student _____ Employer/School _____

Social Security Number: _____ - _____ - _____

Email: _____ @ _____ . _____

Referred by: _____

About the Spouse or Parent

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Relationship _____

Emergency Contact

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (____) _____ - _____

Relationship _____

Experience With Chiropractic

Have you been adjusted by a chiropractor before? (circle one) Yes No

Reason For Visit? _____

Doctor's Name _____ Approximate Date of Last Visit _____

Chief Complaints

Where is your injury/pain located? _____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) ____/____/____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Does the pain shift or radiate from original location? _____

What is the quality of pain? (Check each box that applies)

| | | | | | |
|----------|----------|-----------|----------|-----------|-----------|
| Dull | Sharp | Throbbing | Burning | Deep | Aching |
| Tingling | Stabbing | Cramping | Numbness | Radiating | Stiffness |

What are the aggravating factors? (Check each box that applies)

| | | | | | |
|------------|--------------|--------------|-----------|--------------|----------------|
| Sitting | Standing | Walking | Bending | Stooping | Lifting |
| Sleeping | Sneezing | Coughing | Straining | Reaching | Twisting |
| Looking up | Looking down | Movement | Rest | Lying supine | Driving |
| Typing | Scooping | House chores | Exercise | Lying prone | Stair stepping |

What, if anything, relieves some of the pain? (Check each box that applies)

| | | | | |
|-------------|------------|-------|---------------------|-------------------|
| Sitting | Standing | Lying | Knees bent up | Support |
| No movement | Movement | Heat | Ice | Analgesic topical |
| Ibuprofen | Medication | Rest | Stretching/exercise | Adjustments |

Second Complaint

Where is your injury/pain located? _____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____ / _____ / _____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Does the pain shift or radiate from original location? _____

What is the quality of pain? (Circle each box that applies)

| | | | | | |
|----------|----------|-----------|----------|-----------|-----------|
| Dull | Sharp | Throbbing | Burning | Deep | Aching |
| Tingling | Stabbing | Cramping | Numbness | Radiating | Stiffness |

What are the aggravating factors? (Circle each box that applies)

| | | | | | |
|------------|--------------|--------------|-----------|--------------|----------------|
| Sitting | Standing | Walking | Bending | Stooping | Lifting |
| Sleeping | Sneezing | Coughing | Straining | Reaching | Twisting |
| Looking up | Looking down | Movement | Rest | Lying supine | Driving |
| Typing | Scooping | House chores | Exercise | Lying prone | Stair stepping |

What, if anything, relieves some of the pain? (Circle each box that applies)

| | | | | |
|-------------|------------|-------|---------------------|-------------------|
| Sitting | Standing | Lying | Knees bent up | Support |
| No movement | Movement | Heat | Ice | Analgesic topical |
| Ibuprofen | Medication | Rest | Stretching/exercise | Adjustments |

Third Complaint

Where is your injury/pain located? _____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____ / _____ / _____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

| | | | | | |
|----------|----------|-----------|----------|-----------|-----------|
| Dull | Sharp | Throbbing | Burning | Deep | Aching |
| Tingling | Stabbing | Cramping | Numbness | Radiating | Stiffness |

| | | | | | |
|------------|--------------|--------------|-----------|--------------|----------------|
| Sitting | Standing | Walking | Bending | Stooping | Lifting |
| Sleeping | Sneezing | Coughing | Straining | Reaching | Twisting |
| Looking up | Looking down | Movement | Rest | Lying supine | Driving |
| Typing | Scooping | House chores | Exercise | Lying prone | Stair stepping |

Does the pain shift or radiate from original location? _____

| | | | | |
|-------------|------------|-------|---------------------|-------------------|
| Sitting | Standing | Lying | Knees bent up | Support |
| No movement | Movement | Heat | Ice | Analgesic topical |
| Ibuprofen | Medication | Rest | Stretching/exercise | Adjustments |

Allergies/Medication

Are you currently taking any medication/supplements? (circle one) Yes No

If yes, what kind(s) and dosage? _____

Prescribing physician? _____ Phone #: (____) _____ - _____

Are you allergic to any food/ medication? (circle one) Yes No

If yes, what food/medication? _____

Any hospitalization in the past year? (circle one) Yes No Reason? _____

Surgical history: Date ____ / ____ / ____ Detail? _____ (circle one) In Patient Out Pa-

Social History

Do you smoke? (circle one) Yes No Date Started ____ / ____ / ____ Number of Packs per Day? _____

Date Quite Smoking? ____ / ____ / ____

Do you consume alcohol? (circle one) Yes No Frequency? _____ Type? _____

Do you consume caffeine? (circle one) Yes No Frequency? _____

Do you drink soda? (circle one) Yes No Frequency? _____

Do you drink water daily? (circle one) Yes No Frequency? _____

How much sleep do you average per night? _____

How often do you take pain relievers? _____ per: Day Night Week Month

Recreational Drug Use? (circle one) Yes No Frequency? _____ Type? _____

Are you a healthy eater? (circle one, 1=not at all, 10=very) 0 1 2 3 4 5 6 7 8 9 10

Do you exercise? (circle one) Yes No Frequency? _____ per: Day Night Week Month

Physical Stress Level? (circle one, 1=not at all, 10=high) 0 1 2 3 4 5 6 7 8 9 10

Emotional Stress Level? (circle one, 1=not at all, 10=high) 0 1 2 3 4 5 6 7 8 9 10

Major Stressors? _____

Things to improve? _____

Health goals _____

Comprehensive Questionnaire

Section A: Gastrointestinal

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|---------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Digestive Complaints |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Stomach Complaints |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ulcers |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Heartburn |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Nausea |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Diarrhea |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Constipation |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Irritable Bowel |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hemorrhoids |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Vomiting |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Colitis/Diverticulitis |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Black or Bloody Stool |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Gallbladder Trouble |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Burping/Belching |

Section B: Immune Response

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|-------------------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequently Sick |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Swollen Glands/Sore Throat |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Depression and/or Anxiety |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Achy Joints/Muscle Pain |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Headaches/Migraines |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Digestive Complaints |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Chronic Fatigue |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Food Allergies |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Eczema or Hives |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Allergies (mild/moderate/severe) |

Comprehensive Questionnaire Continued

Section C: Structural/Neurological

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Headaches |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Muscle Cramps/Muscle Spasms |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Neck Pain |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Jaw Pain |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Dizziness |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Back Pain |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Shoulder/Elbow/Wrist Pain (circle one) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Numbness/Tingling |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tremors in Hands or Feet |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Knee Pain/Hip Pain (circle one) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Joint Pain or Loss of Function |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Osteoporosis/Osteomalacia |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Current Bone Fracture or Injury |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tendonitis/Bursitis |

Section D: Cardiovascular

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|----------------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Irregular Heartbeat |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Heart Murmur/Palpitations |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High or Low Blood Pressure |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Chest Pain |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Previous Heart Trouble |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Poor Circulation |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Previous Heart Surgery |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Varicose or Spider Veins |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hands and Feet Cold All the Time |

Section E: Respiratory

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|----------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Chronic Cough |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Asthma |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Emphysema |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Head Colds |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Sinus Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Bronchitis |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Smoker |

Comprehensive Questionnaire Continued

Section F: Genito-Urinary

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Too Frequent Urination |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Discolored or Foul-Smelling Urine |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Blood in Urine |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Kidney or Bladder Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Kidney Stones |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Bedwetting |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Inability to Control Bladder |

Section G: Eyes/Ears

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|--------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Ear Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Eye Infection |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Slowly Losing Vision |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Floaters in Eyes |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Glaucoma |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Macular Degeneration |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cataracts |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetic Retinopathy |

Section H: Men

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Prostate Trouble |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Urination Problems |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Reproductive Problems |

Section H: Women

| N/A | Acute | Chronic | |
|-----------------------|-----------------------|-----------------------|--------------------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Recurrent Urinary Tract Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Yeast Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Vaginal Discharge |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Menstrual Irregularity |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cramping |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Mood Swings/Depression |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pre-menstrual Syndrome |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Infertility |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Miscarriages |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hot Flashes |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Currently Taking Hormone Medication |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Currently Taking Birth Control Pills |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Lumps in Breasts |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Uterine Cysts/Ovarian Cysts |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Bladder Leaks Too Easily |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Endometriosis |

Comprehensive Questionnaire Continued

Section I: Endocrine (Glandular)

N/A Acute Chronic

- | | | | |
|-----------------------|-----------------------|-----------------------|----------------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cold Hands and Feet |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Low Blood Pressure |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Weight Problems (over or under) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Thyroid Problems |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Irritable if Meals are Missed |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Anxiety/Nervousness/Irritability |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Dizzy Upon Standing too Quickly |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Weak and Shaky |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hyperactive Behavior |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Depression |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Very Susceptible to Infections |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Frequent Headaches |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Digestive Complaints |

Diet

Do you have known adverse food reactions, allergies, or sensitivities? Yes No *If yes, describe symptoms and list all foods:*

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or Wired Aches & Pains Headaches

Do you adversely react to: *Check all that apply*

Monosodium Glutamate (MSG) Aspartame (NutraSweet) Preservatives (ex. sodium benzoate)

Cheese Citrus foods Chocolate Alcohol Red Wine Caffeine Bananas Garlic Onion

Sulfite containing foods (wine, dried fruit, salad bars) Other: _____

Environmental & Detoxification Assessment Which of these significantly affect you? *Check all that apply*

Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your home or work environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

How often do you use your cell phone? _____ hrs/day How often do you use your computer? _____ hrs/day _____ hrs/wk

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

If yes, explain _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

Herbicides Insecticides (frequent visits of exterminator) Pesticides Organic Solvents

Heavy Metals Other _____

Chemical Name/Date/Length of Exposure (if known) _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? Yes No

Do you have any pets or farm animals? Yes No

What detergents/soaps do you use (Brand names)? _____

What deodorant? _____

What beauty products do you use (Lotions, Hair products, Make-up, etc.)? _____

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

- Significantly improve your diet _____ 5 4 3 2 1
- Take several nutritional supplements each day _____ 5 4 3 2 1
- Start preparing your own meals _____ 5 4 3 2 1
- Modify your lifestyle _____ 5 4 3 2 1
- Practice a relaxation technique _____ 5 4 3 2 1
- Engage in regular exercise _____ 5 4 3 2 1
- Have periodic lab tests to assess your progress _____ 5 4 3 2 1
- Get regular bodywork such as chiropractic or massage _____ 5 4 3 2 1
- Setting regular appointments _____ 5 4 3 2 1
- Read books or articles to learn about your health and solutions _____ 5 4 3 2 1
- Be fully responsible for your own healing _____ 5 4 3 2 1

Comments: _____

How confident are you of your ability to organize and follow through on the above health related activities? *Rate on a scale of: 5 (very confident) to 1 (not confident at all)* 5 4 3 2 1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?*

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)* 5 4 3 2 1 *Comments:*

_____ How much ongoing support and contact (*office visits*) from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* 5 4 3 2 1 *Please list how often you would be willing to make appointments if needed* _____

Comments: _____

Credit Card Information

In our office services are frequently rendered in anticipation of payment from a health reimbursement account or an insurance company. Any time services are rendered without immediate payment credit is extended. We ask you to guarantee that credit with a personal credit card. Please be assured your card will NEVER be charged without your prior notification.

Please initial each paragraph after you have read it. Thank you.

_____ In the event that my insurance company refuses payment to CT Chiropractic for any reason, I will become personally responsible for that amount. I will have 30 days (once notified by CT Chiropractic) to take care of the outstanding balance by calling my insurance company. If the account is not cleared within 30 days, I am responsible to pay the balance due. I hereby authorize CT Chiropractic to collect any outstanding balance from my credit card (listed below), if I fail to pay the balance due within 30 days.

_____ I will promptly bring any insurance checks that I receive to the office of CT Chiropractic. If I fail to do so within 1 week of receiving it, I understand that my credit card (listed below) may be charged for the amount owed.

_____ If my insurance company fails to pay any portion of my bill, and I do not make payment within 30 days of being notified by CT Chiropractic, I give my permission for CT Chiropractic to charge the credit card (listed below) for the balance due.

_____ Any balance on my account will be paid for and cleared within 30 days of notification of the amount. If a balance remains past 30 days, I hereby authorize CT Chiropractic to collect the amount in full by charging the credit card listed below.

**The signed credit card is only to be used for services rendered at CT Chiropractic.
The doctor agrees not to add any charges directly to my account
for services that were not performed or products not purchased.**

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Credit Card: Visa _____ MasterCard _____

Credit Card Number: _____

Expiration: _____ CVV: _____ Billing Zip _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Terms of Acceptance

_____ When a patient seeks chiropractic health care and we accept a patient for such 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 of chiropractic care in order to attain results. This will prevent any confusion or disappointment.

Adjustment: 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.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: 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 innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during your course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area.

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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ It is the practice of this office to provide chiropractic care in an "OPEN ADJUSTING" environment. Some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

Authorization for Care

_____ I Authorize the Doctor, Kelli Dodge D.C., to work with my condition through the use of adjustments to my spine, as she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

Health Insurance Coverage

_____ I clearly understand that my health insurance is a contract between me and my health insurance company. I understand that this office is providing me with complimentary service by billing my insurance company for me. I agree that any services rendered that are not covered by my insurance policy are solely my financial responsibility.

I, _____ have read, and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office (CT Chiropractic & Wellness Center) have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Sign: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES DISCLOSURE
CT Family Chiropractic, LLC

Please read and understand the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY following this disclosure.

Please indicate with whom we can discuss health information, appointment scheduling and/or billing.

Spouse: _____ Yes, Health Yes, Billing Yes, Scheduling

Parent/s or Guardian/s: _____ Indicate Relationship: _____

Yes, Health Yes, Billing Yes, Scheduling

Relative/Friend/Other: _____ Indicate Relationship: _____

Yes, Health Yes, Billing Yes, Scheduling

Acknowledgment of Receipt of this Notice As a patient of CT Family Chiropractic, I acknowledge that I have read the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY and understand that I may request a copy of the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY for detailed information. I understand that CT Family Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree with all conditions stated in the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY.

Printed Name: _____

Signature of Patient: _____ Date: ____/____/____

(Parent or Guardian Signature if Patient is a Minor)