**1. Patient Information** **Today's Date _____**

Full Name_____ SSN_____ Age _____ DOB _____

Gender: M or F Address_____ City _____ State _____ Zip _____

Height _____ Weight _____ Race_____ Preferred Method of contact: Text/Email/Both

Ethnicity: Hispanic or Latino/ not Hispanic or Latino/ Do not wish to answer

Occupation _____ Employed at _____ Home Phone _____ Cell _____

Email _____ Marital Status: Married Single Divorced Separated Widowed

How did you hear about us? (Please provide name of person is applicable)_____

**2. Health History**

1. Yes/No Skin, hair or nail problems
2. Yes/No Mouth and/or throat problems
3. Yes/No Nose and/or sinus problems
4. Yes/No Ear problems
5. Yes/No. Eyes problems
6. Yes/No Breathing problems
7. Yes/No Smoke tobacco
    a. Status: Every Day smoker/ Occasional smoker / former smoker/ never smoked Start Date: (optional)_____
8. Yes/No Heart/blood vessel problems
9. Yes/No Blood/lymph node problems
10. Yes/No Digestive problems
11. Yes/No Genital problems (e.g. prostate, testicular, vaginal.)
12. Yes/No Urinary problems (including kidney or bladder)
13. Yes/No Mental health problems
14. Yes/No Gland and/or hormone problems
15. Yes/No Allergy or immunity problems
16. Yes/No Muscle, tendon or ligament problems
17. Yes/No Bone or joint diseases

**Females Only - - Additional Health History**

18. Yes/No Menstrual problems
19. Yes/No Taken any form of birth control.
    a. If yes, which type:_____
20. Yes/No Currently pregnant
    How far along _____ LMP_____
21. Yes/No Breast problems

**3. Past History**

22. List all diseases you have had in the past (including childhood diseases e.g. chicken pox):_____

_____

23. Have you ever been diagnosed with a particular condition such as diabetes, cancer, AIDS, etc:

_____

24. Have you ever suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?

Yes/No. If yes, describe accident including date of accident: _____

_____

25. List all surgeries (including appendix, tonsils, ear tubes, wisdom teeth):

_____Date:_____

_____Date:_____

_____Date:_____



26. Have you ever been hospitalized for any reason other than surgery? Yes/No

What?_____When?_____

27. Medications: Please list all medications (prescription and non-prescription) your are currently taking or take on an occasional basis:_____

Medication allergies:_____Reaction:_____

28. Have you ever had cancer? Yes/No If yes, describe:_____

_____

**4. Family History**

29. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases/conditions?) Yes/No If yes, describe:_____

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**5. Social History**

30. In which position do you usually sleep well and how well?_____

31. Do you exercise on a regular basis? Yes/No If yes, how?_____

32. How do you spend your spare time? (Hobbies, etc.)?_____

33. How would you describe your diet? Balanced/Fair/Poor/Excessive/Restrictive

34. Do you use: Caffeine/Tobacco/Nicotine/Recreational Drugs/Alcohol

35. Describe your work (select all that apply):

    Type:_____ Retired/Professional/Physical Labor/Driver/Athlete/Clerical/Factory/Homemaker/Student/Child

    Physical Demands: Heavy/Moderate/Mild/Sedentary

    Stress Level: High/Medium/Low



**6. Additional History**

36. If there is any information about your health history that was not requested, please fill it in:

_____

37. Please describe your current complaint. In other words, what brings you in today? Is it related to an accident or injury?_____

38. Who is your medical doctor?_____

39. Have you had any spinal imaging done this year? Yes/No If yes, where?_____

40. Have you ever seen a chiropractor before? Yes/No If yes, date?_____

41. Have you ever seen a physical therapist before? Yes/No If yes, date?_____

42. Have you had previous treatment(s) for you current condition? (Select all that apply)

Physical therapy Biofeedback Acupuncture Occupational therapy

Psychological counseling Massage Chiropractic Psychiatric treatment

Trigger point injections TENS Bed Rest Epidurals or other spinal injections

Patients signature:_____Date:_____

Guardian or Spouse's signature:_____Date:_____

NOTICE TO PATIENTS

We work hard to provide the best, most efficient and affordable chiropractic healthcare. In order to provide our high quality of service and efficiency we must keep our costs down. We work for you. However, we do reserve the right to dismiss you as a patient if you miss more than 3 appointments without prior notice. This arrangement will allow our office to maintain a level of service to each and every patient as each patient counts on our quality and efficiency of service and care.

Requests by patients for x-rays will be processed in 24 hours. The patient is responsible for their x-rays once they are released from Elevate Chiropractic until they are returned.

CONQUER™

CHIROPRACTIC

ASSIGNMENT OF BENEFITS FORM

Name of Policy Holder (print): _____

Social Security Number: _____

□ Medicare is my primary insurance

□ _____ is my primary insurance

□ I am not seeking care in connection with an accident or injury

I request that payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) be made on my behalf to Elevate Chiropractic (the "Provider" ) for any equipment or services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to (i) the Provider, (ii) the Centers for Medicare and Medicaid Services ( "CMS" ), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked, in writing, by me.

I understand that I am financially responsible to the Provider for any charges not covered by healthcare benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for exams, maintenance treatments and that I am responsible for paying for these services out-- rays, physical therapy treatments, or of pocket. I also authorize payment of all medical benefits that apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the provider.



In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial equipment, and services provided by the Provider. all responsibility, as explained above, for all payment, I also understand that in the event it becomes necessary to employ a collection agency service to enforce payment under this Agreement/Contract, I agree to pay for collection costs and fees equal to fifty (50) percent of the delinquent balance associated with the collection thereof, including but not limited to, attorney's fees and court costs. By signing this document, I also acknowledge that I have received a copy of the Provider's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____Date:_____

**CONSENT FOR TREATMENT AND USE OF PROTECTED HEALTH INFORMATION**

Chiropractors focus on dysfunctions that can result from irregularities of spinal structure or movement. Hands-on procedures are usually preferred by most chiropractors to determine structural and functional problems. Manipulation is used to promote normal bodily function thus correcting or preventing these structural deviations. Chiropractic "adjustment" refers to a variety of manual mechanical interventions. Chiropractic adjustments and other procedures are usually beneficial and seldom cause any harm to the patient. In most cases, there is gradual but satisfactory result from chiropractic treatment. Occasionally, the results are less than expected. In rare cases, however, unknown underlying defects, deformities, or pathologies may result in injury to the patient including and not limited to increased pain, spasm, broken ribs, and although rare stroke from vertebrobasilar artery dissection. I understand that results of chiropractic only treatment vary, and I have disclosed all known latent pathological defects, illnesses, and deformities to my chiropractor.

_____ _____

Signature Date

I consent to diagnosis and treatment options available to me and consent to receive services from Elevate Chiropractic ("the Practice").

_____ _____

Signature Date

I consent the Practice to use the following methods to remind me of my appointments: a postcard mailed to my address, a message left on the voicemail of any telephone number provided by me to the Practice, a text message to the cell phone number provided by me to the Practice, or a message left with any individual answering any telephone number provided by me to the Practice.

_____ _____

Signature Date

I consent to having treatments performed in an open area, which may be visible to other patients. The Practice will accommodate any reasonable request to discuss matters in private with me.

_____ _____

Signature Date