

Name (First, M.I. and Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: Married Divorced Widowed Single Separated

Spouse or Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been involved in a motor vehicle accident or work-related injury? Yes No

 If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor or Other Physician Treating you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you consulted with a chiropractor before?** Yes No

**Do you take any vitamins or supplements? IF yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What aspects of wellness do you want for yourself? (Please check all that apply)**

{ } Improve Sports Performance { } Improve Posture

{ } More Energy { } Better Sleep

{ } Better Concentration { } Improve Nutrition

{ } Reduce/Eliminate Medications { } Increase Enjoyment of Life

{ } Quality Exercise { } Greater Resistance to Sickness

{ } Decrease Stress { } Better Balance

{ } Improve Digestion { } Freedom from Pain

What do you want the MOST out of your experience here at the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Health History Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following problems?

|  |  |  |
| --- | --- | --- |
| * Broken Bones
 | * Heart Problems
 | * High Blood Pressure
 |
| * Surgery
 | * Diabetes
 | * Head Injury
 |
| * Arthritis
 | * Thyroid Problem
 | * Headache
 |
| * Insomnia
 | * Cancer
 | * Prostate Problem
 |
| * Depression
 | * Anxiety
 | * Sinus Problems
 |
| * Allergies
 | * Fatigue
 | * Kidney Problems
 |
| * Asthma
 | * Bowel Problems
 |  |
|  |  |  |
| **Women Only:** | * Pregnant?

Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ |
|  | * Menopause
 | * LMP:\_\_\_\_\_\_\_\_\_\_\_\_
 |

If you answered yes to any of the above, please explain briefly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications, foods, or latex? No Yes

If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications or Supplements Taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History:

Smoke ? No Yes How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol No Yes How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 Patient Complaint Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is your pain? **Circle the parts of the body that hurts:**

 **Complaint 1 Complaint 2**



|  |  |
| --- | --- |
| **On a scale of 1-10****how would you rate your pain?**1 2 3 4 5 6 7 8 9 10  | **On a scale of 1-10****how would you rate your pain?**1 2 3 4 5 6 7 8 9 10 |
| **How do you describe the pain?**(Circle all that apply)

|  |  |  |
| --- | --- | --- |
| DullShootingBurning | SharpSpasmTingling | AchingThrobbingNumbness |
|  |  |  |
|  |  |  |
|  |  |  |

 | **How do you describe the pain?**(Circle all that apply)

|  |  |  |
| --- | --- | --- |
|   |  |  |
|  |  |  |
| DullShootingBurning | SharpSpasmTingling | AchingThrobbingNumbness |

 |
| **Is the pain?**Constant Frequent Occasional | **Is the pain?**Constant Frequent  Occasional |
| **Did the pain start** **gradually or suddenly?** (Circle One) | **Did the pain start** **gradually or suddenly?** (Circle One) |
| **Does anything make****the pain better?** | **Does anything make****the pain better?** |
| **Does anything make****the pain worse?** | **Does anything make****the pain worse?** |



**Terms of Acceptance and Consent for Treatment and Care**

It is important that each patient understands the objective of chiropractic care and the methods that will be used while receiving care. These include but are not limited to Adjustments or Manual Manipulation of the Spine, Massage, Application of Heat or Cold, Traction, Acupressure and Acupuncture.

Chiropractic care is given as a result of having vertebral subluxation or a misalignment of one or more vertebra in the spine. We cannot offer to diagnose or treat any other disease or condition other than vertebral subluxation. However, if in the course of chiropractic exam and care, if something unusual or abnormal is noticed, you will be informed, and we will recommend seeking care from a provider specializing in that area.

We cannot comment, refute, affirm, or object to any other providers’ diagnosis, treatment or care. We can, however, provide you with the proper care based on your current condition using a chiropractic exam and any previous medical history presented by you. It is important to have full disclosure regarding your past medical history in order to assess any chiropractic condition accurately.

**Please sign acknowledging that you understand the condition in which chiropractic care is given and that you accept the above statements.**

**I agree that all information I provide the Doctor of Chiropractic is accurate to the best of my knowledge.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

****

Patient Privacy Notice

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment, and Healthcare Operations

I hereby state that by signing this Consent, I acknowledge and agree as follows:

**1.** The practice’s Privacy Notice has been provided to me prior to my signing this Patient Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my PHI necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The practice has further explained my right to obtain a copy of the available Privacy Notice prior to my signing this consent.

**2.** The practice reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law.

**3.** I understand that the practice’s “Notice of Privacy Practices”(NOPP) that describes my rights and the duties of this office with respect to my PHI is available to me and that I may request a copy from this office at any time via US Mail.

**4.** The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

**5.** I understand that I have a right to request that the practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the practice.

**6.** I understand and consent to the fact that the majority of the treatments performed at the practice take place in an open adjustment area, and that unless personal information needs to be discussed with the doctor of practice or prior arrangements have been made, I too will be treated in the open adjustment area. I further understand that during my appointment others may also be present in the open adjustment area receiving adjustments and/or other treatments at the same time I am.

**7.** I understand and consent to the following appointment reminders that will be used by the practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

**8.** I understand and consent to the following other types of correspondence from this office: a) a birthday card may be mailed to me at the address I provided; and b) I may receive periodic mailings of general health information in the form of a newsletter.

**9.** I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing at any time, for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on the consent.

**10.** I understand that if I do not sign this consent or revoke consent at any time, the practice has the right to refuse to treat me.

**I have read and understand the above notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Individual Name of Individual (Printed)