Patient Information

Name: ____ Birth Date: ____/____/____ Age: _________ Gender: M F

Address: ____ City: ______________________ State: _______ Zip: _________

Cell Phone: ( ) __________________ Work Phone: ( ) __________________ Home Phone: ( ) _________________

Email: ____________________________ Social Security #: ______/______/______ Marital Status: S M D W

Occupation:____ Employer Name:_______________________________________

Spouse's Name:____ Spouse's Employer:_____________________________________

Do you have any children? ❑ Yes ❑ No If yes, what are their name and age: ____

How were you referred to this office? ____

Experience with Chiropractic

Have you seen a chiropractor before? ❑Yes ❑No If yes, how often?______ day(s) per week; Other:__________________

Reason for previous chiropractic visit(s):____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑Yes ❑No What was the diagnosis?____________________

Did he or she recommend a specific course of treatment? ❑Yes ❑No

Did they recommend a Home Rehabilitation program? ❑Yes ❑No

If yes, what was it? ____

How did you respond to care?____

Is there anything that you particularly 'liked' or 'disliked' about your previous chiropractic care? ❑Yes ❑No ❑N/A

If yes, please explain:____

Are you aware of any poor posture habits? ❑Yes ❑No Is there a history of spinal problems in your family? ❑Yes ❑No

If yes, please explain: ____

Lifestyle

Do you exercise? ❑Yes ❑No How often? _____ day(s) per week; Other:____________________________________

What activities? ❑Walking ❑Running/Jogging ❑Weight Training ❑Cycling ❑Yoga ❑Pilates ❑Swim ❑Other_______

Do you smoke? ❑Yes ❑No How much?/ How often? ____

Do you drink alcohol? ❑Yes ❑No How much?/ How often? ____

Do you drink coffee? ❑ Yes ❑ No How much?/ How often? ____

In Case of Emergency

Name: ____ Relationship to Patient: ______________________________

Phone: Cell( ) _____________________ Home( ) _______________________ Work ( ) _______________________

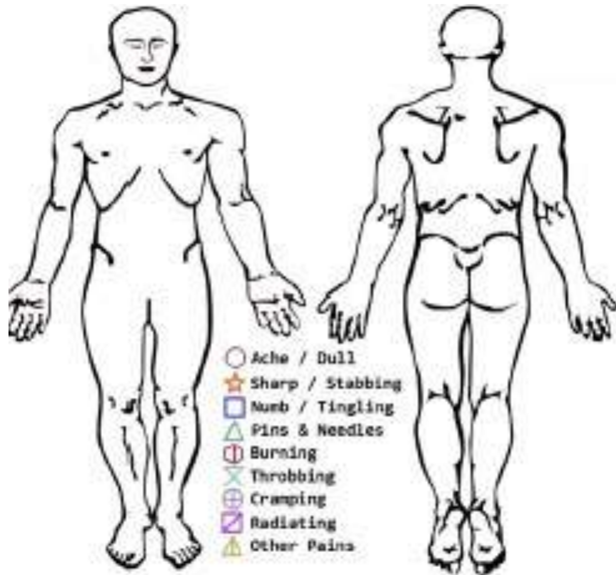
Reason for your Visit

Purpose of appointment ____

Is this visit the result of: ❑ auto accident ❑ sports injury ❑ work injury ❑ trauma ❑ chronic problem ❑ other

Please fill out a separate diagram and question series for EACH area of complaint.

Mark where it hurts



Complaint #1

When did this condition begin? ____________ What caused it?________________

Is the pain: ❑ constant ❑ frequent ❑ off and on ❑ random ❑ recurring ❑ other

What is the quality of the pain? ❑ aching ❑ burning ❑ deep ❑ dull ❑ pulling

❑ sharp ❑ stabbing ❑ throbbing ❑ tingling ❑ other_______

Is it: ❑ improving ❑ staying the same ❑ worsening

Rank 0-10 (10 is worst): _____/10

What improves this condition? ❑ chiropractic ❑ cold packs ❑ exercise ❑ heat

❑ massage ❑ nothing ❑ OTC meds ❑ Rest ❑ stretching ❑ other _________

What aggravates this condition? ____

Previous episodes of this condition? ❑ No ❑ Yes _____________

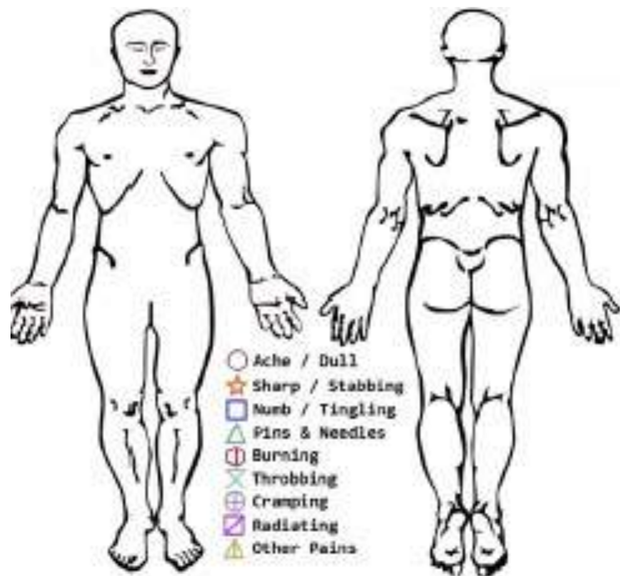
What treatment have you received up to now? ❑ none ❑ acupuncture

❑ chiropractic ❑ homeopathy ❑ injections ❑ prescription meds ❑ physical therapy ❑ psychotherapy ❑ other ______________________________________

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc…)

❑ Yes ❑ No ❑ Unsure

Mark where it hurts



Complaint

When did this condition begin? ____________ What caused it?________________

Is the pain: ❑ constant ❑ frequent ❑ off and on ❑ random ❑ recurring ❑ other

What is the quality of the pain? ❑ aching ❑ burning ❑ deep ❑ dull ❑ pulling

❑ sharp ❑ stabbing ❑ throbbing ❑ tingling ❑ other_______

Is it: ❑ improving ❑ staying the same ❑ worsening

Rank 0-10 (10 is worst): _____/10

What improves this condition? ❑ chiropractic ❑ cold packs ❑ exercise ❑ heat

❑ massage ❑ nothing ❑ OTC meds ❑ Rest ❑ stretching ❑ other _________

What aggravates this condition? ____

Previous episodes of this condition? ❑ No ❑ Yes _____________

What treatment have you received up to now? ❑ none ❑ acupuncture

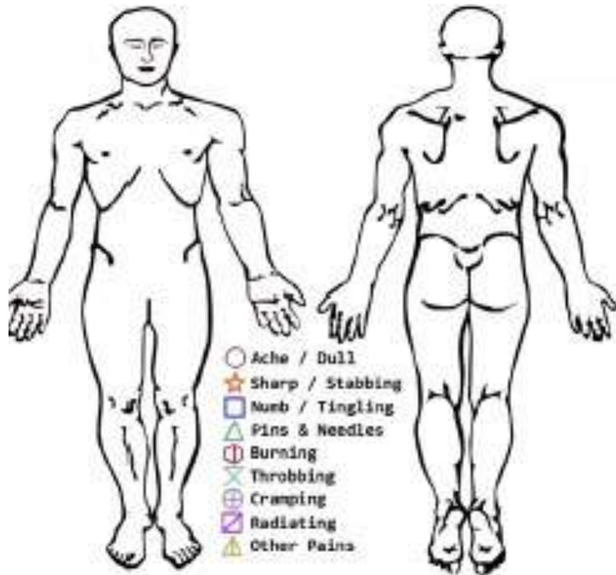
❑ chiropractic ❑ homeopathy ❑ injections ❑ prescription meds ❑ physical therapy ❑ psychotherapy ❑ other ______________________________________

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc…)

❑ Yes ❑ No ❑ Unsure

Please fill out a separate diagram and question series for EACH area of complaint.

Mark where it hurts



Complaint #3

When did this condition begin? ____________ What caused it?________________

Is the pain: ❑ constant ❑ frequent ❑ off and on ❑ random ❑ recurring ❑ other

What is the quality of the pain? ❑ aching ❑ burning ❑ deep ❑ dull ❑ pulling

❑ sharp ❑ stabbing ❑ throbbing ❑ tingling ❑ other_______

Is it: ❑ improving ❑ staying the same ❑ worsening

Rank 0-10 (10 is worst): _____/10

What improves this condition? ❑ chiropractic ❑ cold packs ❑ exercise ❑ heat

❑ massage ❑ nothing ❑ OTC meds ❑ Rest ❑ stretching ❑ other _________

What aggravates this condition? _______________________________________

Previous episodes of this condition? ❑ No ❑ Yes _____________

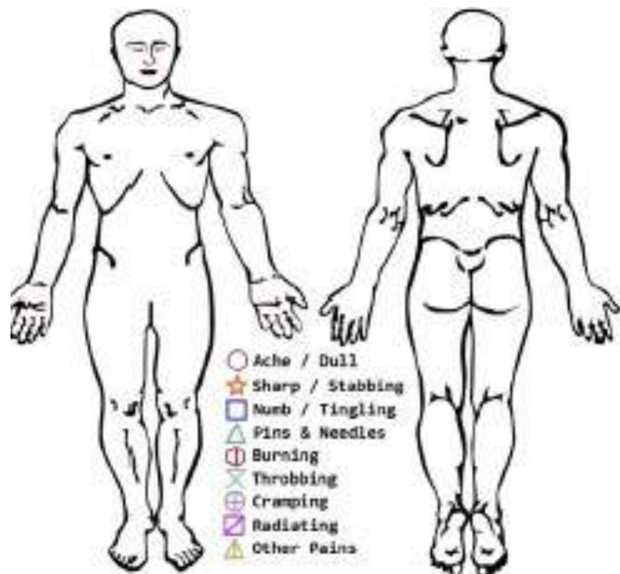
What treatment have you received up to now? ❑ none ❑ acupuncture

❑ chiropractic ❑ homeopathy ❑ injections ❑ prescription meds ❑ physical therapy ❑ psychotherapy ❑ other _____________________________________

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc…)

❑ Yes ❑ No ❑ Unsure

Mark where it hurts



Complaint #4

When did this condition begin? ____________ What caused it?________________

Is the pain: ❑ constant ❑ frequent ❑ off and on ❑ random ❑ recurring ❑ other

What is the quality of the pain? ❑ aching ❑ burning ❑ deep ❑ dull ❑ pulling

❑ sharp ❑ stabbing ❑ throbbing ❑ tingling ❑ other_______

Is it: ❑ improving ❑ staying the same ❑ worsening

Rank 0-10 (10 is worst): _____/10

What improves this condition? ❑ chiropractic ❑ cold packs ❑ exercise ❑ heat

❑ massage ❑ nothing ❑ OTC meds ❑ Rest ❑ stretching ❑ other _________

What aggravates this condition? _______________________________________

Previous episodes of this condition? ❑ No ❑ Yes _____________

What treatment have you received up to now? ❑ none ❑ acupuncture

❑ chiropractic ❑ homeopathy ❑ injections ❑ prescription meds ❑ physical therapy ❑ psychotherapy ❑ other _____________________________________

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc…)

❑ Yes ❑ No ❑ Unsure

Health Conditions - Review of Systems

Your spine is the foundation of health and strength for your body. Shifts in vertebrae can cause the body to compensate and render the entire structure weak. Research shows that abnormal posture leads to chronic pain, disease, and possibly shorten life span.
(Postural and Degenerative Kyphosis: Freeman JT. Poster in the Aging and Aged Body. JAMA 1957, Oct 19:843-846.)

(Please circle the appropriate number "0-3" on all questions below. 0 - never 3 - frequent)

CERVICAL SPINE (NECK)

Neck Pain 0 1 2 3
Pain in shoulders/arms/hands..........0 1 2 3
Numbness/tingling in arms/hands.. 0 1 2 3
Hearing Disturbances....................... 0 1 2 3
Weakness in Grip.............................. 0 1 2 3

Headaches 0 1 2 3
Dizziness 0 1 2 3
Visual Disturbances........................ 0 1 2 3
Coldness in Hands...................... ...0 1 2 3
Thyroid Conditions......................... 0 1 2 3

Sinusitis 0 1 2 3
Allergies/Hay Fever 0 1 2 3
Recurrent Colds/Flu............0 1 2 3
Low Energy/Fatigue........... 0 1 2 3
TMJ/Pain/Clicking............... 0 1 2 3

THORACIC SPINE (UPPER BACK)

Heart Palpitations..................... ......0 1 2 3
Heart Murmurs 0 1 2 3
Tachycardia.......................................0 1 2 3
Heart Attacks/Angina....................... 0 1 2 3

Recurrent Lung Infections...............0 1 2 3
Asthma/Wheezing 0 1 2 3
Shortness of Breath..........................0 1 2 3
Gas following a Meal...................... 0 1 2 3

Unstable blood sugar 0 1 2 3
Gas following meal 0 1 2 3
Excessive burp/bloating.......0 1 2 3
Difficulty digesting fruits or Vegetables............................0 1 2 3

THORACIC SPINE (MID BACK)

Mid Back Pain............................ ....0 1 2 3
Pain in ribs/Chest 0 1 2 3
Indigestion/Heartburn.......................0 1 2 3
Tired/Irritable after eating............... 0 1 2 3

Nausea..................... ....0 1 2 3
Ulcers/Gastritis 0 1 2 3
Reflux...0 1 2 3
Tired/Irritable for missed meals......0 1 2 3

Diabetes 0 1 2 3
Hypoglycemia 0 1 2 3
Hyperglycemia.....................0 1 2 3

LUMBAR SPNE (LOW BACK)

Lower back pain..................... ....0 1 2 3
Pain in hips/legs/feet 0 1 2 3
Numbness/tingling in legs/feet......0 1 2 3
Frequent/difficulty urinating.......... 0 1 2 3

Weak/Injuries in hip/knee/ankle....0 1 2 3
Recurrent Bladder Infections.... ......0 1 2 3
Muscle Cramps in Legs/Feet...........0 1 2 3
Menstrual Irregularities/Cramping. 0 1 2 3

Coldness in legs/feet...............0 1 2 3
Sexual dysfunction...................0 1 2 3
Constipation/Diarrhea.............0 1 2 3

Family Health History

Have any of your family members ever been diagnosed with the following (please indicate "Y" for You, "O" for Other than you, or both if applicable):

___Diabetes
___Circulatory Problems
___Cancer
___Arthritis
___Broken bones
___Bronchitis
___Chicken Pox
___Influenza

___Varicose Veins
___Stroke
___Osteoporosis
___Liver Disease
___Appendectomy
___Polio
___Mumps
___Pleurisy

___Neurological Problems
___Heart Murmur
___Kidney Disease
___Metal Implants
___Tonsillectomy
___Tuberculosis
___Measles
___Blood Sugar Problems

___Lung Disease
___High Blood Pressure
___Paralysis
___Infectious Disease
___Hernia
___Anemia
___Thyroid
___Epilepsy/Seizures

___Rheumatic Fever
___Heart Disease
___Migraines
___Gall Bladder
___Pneumonia
___Whooping Cough
___Small Pox
___Eczema

OTHER:

Please list any conditions not mentioned:

____

Please list any medications and supplements that you take (include name, dose, for what condition and for how long you've taken it):

____

Please list any surgeries (include type of surgery and date it was performed):

____

Informed Consent for Diagnostic X-Rays and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy, including but not limited to ice, heat, massage, laser, spinal decompression, MyACT and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of Health First Spine & Wellness or any doctor, who now or in the future works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, dislocations, sprains, soreness etc.. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing.

I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest. This consent will cover entire course of treatment for my present condition and for all future conditions.

Patient Signature: __________________________________Date: ______/______/_______

Insurance Authorization

I authorize payment of insurance benefits directly to Health First Spine & Wellness, I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Health First to communicate with my medical physician(s) about my condition and treatment. I understand and agree that **ultimately I am responsible for all costs** of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

Although our office do a courtesy insurance check, **it is your responsibility to confirm and know your benefits**.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

I intend this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment in this office.

Patient Signature: __________________________________Date: ______/______/_______

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____ Patient Signature: _______________________________________ Date: _____/_____/_____

Consent to Treatment of a Minor

I hereby authorize the doctors of HealthFirst Spine & Wellness, and/or whomever the may sesignate as assistants, to administer treatment as deemed necessary to ____.

Signature of Parent or Legal Guardian ____ Relationship __________________

Date: _____/_____/_____

Patient Health Information Consent Form

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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information 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 assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.

Signature ____ Date _____/_____/_____