About the Patient

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Gender: _____ Number of children: _____

Employer: _____

Marital Status: _____

Insured Date of Birth: _____

Preferred Phone Number: _____

Alternative Phone Number: _____

Email: _____

Please check the box if you agree:

◯ I authorize correspondence via email and/or texts for appointments, receipts, and other communication even though these modes are not HIPAA compliant.

How did you hear about our office?

_____

Emergency Contact

Name: _____

Relation: _____

Phone number: _____

Health Habits

Do you smoke? Y / N

If yes, how much per day? _____

Do you drink alcohol? Y / N

If yes, how many beverages per week? _____

Do you have caffeine daily? Y / N

If yes, how many beverages per day? _____

Do you exercise? Y / N

If yes, how many minutes per week? _____

How much water do you drink per day? _____

How would you describe your overall diet:

Poor Fair Good Excellent

Purpose of Care

Describe the reason for your visit:

_____

_____

When did it begin?

_____

How did it start?

_____

Is the condition:

Getting better Staying the same Getting worse

What percentage of the day does it occur?

0-25% 25-50% 50-75% 75-100%

Please rate severity of the condition:

Least 0 1 2 3 4 5 6 7 8 9 10 Most

What is the nature of the pain?

Aching Numbness Sharp Shooting Tingling

Does the condition interfere with any of the following:

Work Sleep Daily routine Other activities

What makes symptoms better?

_____

What makes symptoms worse?

_____

Has this occurred before? Y / N

List any other care you have received in regards to the complaint: _____

Please share other questions or concerns needing to be addressed:

_____

_____

_____

FAMILY CHIROPRACTIC

Health History

Please list any allergies:

_____

_____

Please list any surgeries:

_____

_____

Please list any current medications & supplements:

_____

_____

Have you seen a chiropractor before? Y / N

If yes, how long ago: _____

Have you ever had x-rays or MRI of your spine? Y / N

If yes, how long ago and what region: _____

Does you have regular medical care? Y / N

If yes, where: _____

Have you ever suffered any spinal trauma? Y / N

(i.e. significant fall, car accident, sports injury, etc.)

If yes, please explain: _____

_____

Family History

Please indicate any pertinent family history of the following conditions:
(P=parent, GP=grandparent, O=other relative)

Arthritis	P	GP	O
Autoimmune condition	P	GP	O
Cancer	P	GP	O
Diabetes	P	GP	O
GI disorder	P	GP	O
Headache/Migraine	P	GP	O
Heart disease	P	GP	O
High blood pressure	P	GP	O
Mental illness	P	GP	O
Neurological disorder	P	GP	O
Osteoporosis	P	GP	O
Stroke	P	GP	O
Scoliosis	P	GP	O

Authorization

Please read thoroughly, initial at each applicable section and sign the bottom. Thank you!

Possible risk of chiropractic treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you can make an informed decision about whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. As with any health procedure, complications may arise during treatment. These complications include but are not limited to soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are rare occurrences. Doctors of chiropractic, medical doctors, and physical therapists using manual therapy treatment for patients with headaches and cervical spine complaints are required to explain that there may be rare cases of injury to the vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have questions about this, please speak with your practitioner. It is your responsibility to communicate to the Doctor any condition that otherwise would not come to the Doctor's attention.

Consent for treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

NON-HIPAA communication

_____ I understand when I contact the office through social media or email, I am waiving my HIPAA rights as there can be no guarantee that my information can maintain confidential through these routes of communication.

Guarantee of payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of ABC Family Chiropractic. I authorize the facility to release all information necessary to secure the payment of benefits. If my care is not covered through my insurance carrier, I understand that I hold personal financial obligation for payment.

_____ _____

Patient signature **Date**

Review of Systems

Please check those applicable and mark "P" for past conditions and "C" for current health:

General:

- ○ difficulty sleeping
- ○ chronic pain
- ○ frequent chills
- ○ frequent fatigue
- ○ sudden weight loss / gain
- ○ cancer

Vision:

- ○ blindness
- ○ glaucoma
- ○ cataracts
- ○ blurred vision
- ○ double vision
- ○ itchy eyes
- ○ eye pain
- ○ light sensitivity
- ○ tearing / dry eyes
- ○ wear glasses / contacts

Head/Ears/Nose/Throat:

- ○ frequent headache
- ○ migraine
- ○ concussion
- ○ ear infection
- ○ tubes in ears
- ○ hearing loss
- ○ hearing aids
- ○ tinnitus
- ○ TMJ
- ○ frequent nosebleeds
- ○ snoring
- ○ deviated septum
- ○ frequent runny nose
- ○ frequent sore throat
- ○ difficulty swallowing

Respiration:

- ○ asthma
- ○ coughing up blood
- ○ shortness of breath
- ○ wheezing

Cardiovascular:

- ○ low / high blood pressure
- ○ chest pain
- ○ shortness of breath
- ○ heart murmur
- ○ palpitations
- ○ pacemaker
- ○ high cholesterol

Gastrointestinal:

- ○ abdominal pain
- ○ heartburn
- ○ reflux
- ○ frequent diarrhea
- ○ frequent constipation
- ○ irregular stool
- ○ ulcer
- ○ hernia
- ○ Irritable Bowel Disease
- ○ Crohn's Disease
- ○ Celiac Disease

Endocrine:

- ○ diabetes
- ○ extreme hunger / thirst
- ○ hair loss / growth
- ○ thyroid condition

Skin:

- ○ eczema
- ○ psoriasis
- ○ frequent hives

Neurological:

- ○ dizziness
- ○ numbness
- ○ weakness
- ○ tremor
- ○ balance problems
- ○ stroke
- ○ memory loss
- ○ seizure

Physiological:

- ○ depression
- ○ mental health disorder
- ○ anxiety
- ○ substance abuse

Hematological:

- ○ anemia
- ○ clotting disorder
- ○ varicose veins
- ○ circulation concern

Women's Health:

- ○ birth control
- ○ irregular periods
- ○ hormone therapy
- ○ pregnancy
- ○ urinary incontinence
- ○ fibroids
- ○ endometriosis
- ○ PCOS
- ○ menopause

Men's Health:

- ○ urination issues
- ○ prostate issues

Other:

_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your healthcare information.

- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have the right to receive a copy of this notice.

_____ _____

Printed Name Signature

_____

Date