HEALTH INTAKE FORM

PATIENT DATA

TITLE: ❑ MR. ❑ MRS. ❑ MS. ❑ MISS ❑ DR. ❑ PROF. ❑ REV. (CHECK ONE)		DATE:
FIRST NAME:	NICK NAME:	
LAST NAME:	MIDDLE NAME:	SUFFIX:
ADDRESS LINE 1:		
ADDRESS LINE 2:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	
CELL PHONE:		
HOME EMAIL:	WORK EMAIL:	

Which Email address would you like us to use to communicate with you? (check one) ❑ Home ❑ Work

CONTACT METHOD: (check one)

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Home Email ❑ Work Email

DOB:	/ /	AGE:	SSN:
GENDER: ❑ Male ❑ Female ❑ Unspecified		MARITAL STATUS: ❑ Single ❑ Married ❑ Other	

RACE: (check one)

❑ White /Caucasian	❑ Black /African American	❑ Hispanic
❑ American Indian/Alaskan Native	❑ Asian	❑ Asian Indian
❑ Chinese	❑ Filipino	❑ Japanese
❑ Korean	❑ Vietnamese	❑ I choose not to specify
❑ Samoan	❑ Guamanian or Chamorro	❑ Other_____
❑ Native Hawaiian or other Pacific Island		

MULTI-RACIAL: (check one) ❑Yes ❑No ❑Unknown

ETHNICITY: (check one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑I choose not to specify

PREFERRED LANGUAGE: (check one)

❑ English	❑ Spanish	❑ Chinese	❑ ASL (American Sign Language)
❑ French	❑ German	❑ Tagalog	❑ Vietnamese
❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole
❑ Greek	❑ Hindi	❑ Persian	❑ Urdu
❑ Gujarati	❑ Armenian	❑ I choose not to specify	

VERIFICATION QUESTION: (choose only one question by circling the question, then give the answer to that question)

❑ What is the name of your favorite pet?	❑ In what city were you born?	❑ What High School did you attend?
❑ What is your mother's maiden name?	❑ What is your favorite movie?	❑ On what street did you grow up?
❑ What was the make of your first car?	❑ When is your anniversary?	❑ What is your favorite color?

Verification Answer to the Chosen question:_____

_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ No ❑ Former Smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current Sometimes smoker

If yes, what is your level of interest in quitting smoking?

(No interest) 0 1 2 3 4 5 6 7 8 9 10 (very interested)

Current medications, including dosage if known. If there are no current medications, check here:

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

List any known allergies you have had to any medications. If no allergies known, check here:

1)_____ 3)_____

2)_____ 4)_____

Briefly list you main health problems:_____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No ❑ If yes, describe:_____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes:_____

Have you had an X-ray, CT Scan, or MRI of your low back spine in the past 28 days? Yes No

To be performed by clinic staff:

Height:_____inches Weight:_____pounds BP:_____/_____

WHAT IS YOUR OCCUPATION:					
IF YOU ARE NOT RETIRED, A HOMEMAKER OR A STUDENT, WHAT IS YOUR WORK STATUS?					
❑ FULL-TIME	❑ PART-TIME	❑ SELF EMPLOYED	❑ UNEMPLOYED	❑ OFF WORK	❑ OTHER
EMPLOYER NAME:			PHONE NUMBER:		
CITY:		STATE:		ZIP:	
IS IT OKAY TO CALL YOU AT WORK? ❑ YES ❑ NO					

PRIMARY CARE PHYSICIAN		
PRIMARY CARE PHYSICIAN NAME:		
PRACTICE NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NUMBER:		

SPOUSE DATA	
IS YOUR SPOUSE A PATIENT IN THE CLINIC? YES NO	
FIRST NAME:	MI:
LAST NAME:	
HOME PHONE:	WORK PHONE:
DATE OF BIRTH:	

EMERGENCY CONTACT	
CONTACT NAME:	CONTACT PHONE:
RELATIONSHIP:	

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR CLINIC? OR WHO REFERRED YOU?

❑ FAMILY MEMBER ❑ FRIEND ❑ PHYSICIAN ❑ EMPLOYER ❑ ATTORNEY ❑ BROCHURE

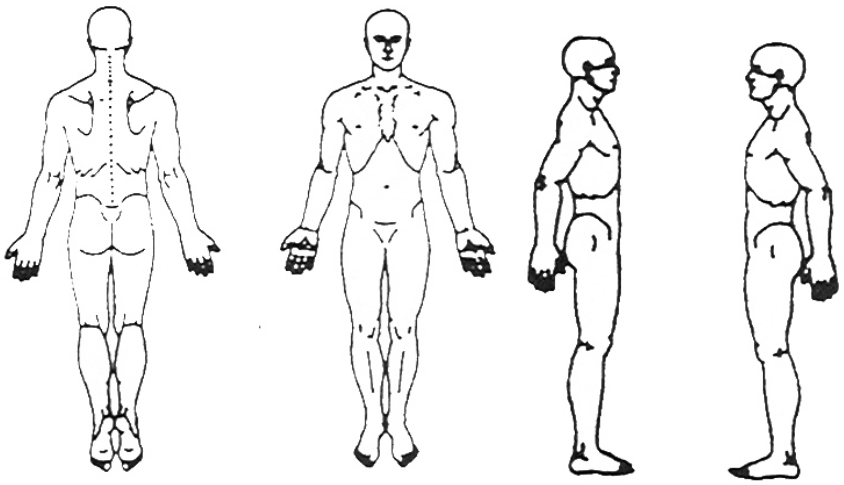
❑ SIGN ON BUILDING ❑ INTERNET WEB SITE ❑ HEALTH CLASS ❑ OTHER

IF YOU SELECTED "FAMILY MEMBER, FRIEND, OR PHYSICIAN" PLEASE ENTER THEIR NAME:

IF YOU SELECTED "OTHER" PLEASE DESCRIBE:

BY USING THE KEY BELOW, INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS:

 # = NUMBNESS X= BURNING / = STABBING 0 = PINS&NEEDLES + = DULL ACHE



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

DESCRIBE YOUR SYMPTOMS: _____

_____

_____

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN? (IF THERE WAS AN ACCIDENT, INJURY OR FALL, PLEASE DESCRIBE)

_____

_____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- ❑ **CONSTANTLY (76%-100% OF THE DAY)**
- ❑ **FREQUENTLY (51%-75% OF THE DAY)**
- ❑ **OCCASIONALLY (26%-50% OF THE DAY)**
- ❑ **INTERMITTENTLY (0%-25% OF THE DAY)**

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS

- ❑ **DULL**
- ❑ **SHARP**
- ❑ **SHARP WITH MOVEMENT**
- ❑ **THROBBING**
- ❑ **BURNING**
- ❑ **DEEP**
- ❑ **ACHING**
- ❑ **TINGLING**
- ❑ **STABBING**
- ❑ **CRAMPING**
- ❑ **PINPRICK**
- ❑ **NUMBNESS**
- ❑ **RADIATING (WHERE)?** _____

HOW ARE YOUR SYMPTOMS CHANGING? ❑ **GETTING BETTER** ❑ **NOT CHANGING** ❑ **GETTING WORSE**

ARE YOUR SYMPTOMS:

- ❑ **THE SAME ALL THE TIME**
- ❑ **WORSE** - ❑ IN THE MORNING ❑ BY MIDDAY ❑ AT THE END OF THE DAY ❑ AT NIGHT ❑ THROUGHOUT THE DAY ❑ AT NIGHT W/PAIN
- ❑ **BETTER** - ❑ IN THE MORNING ❑ BY MIDDAY ❑ AT THE END OF THE DAY ❑ AT NIGHT ❑ THROUGHOUT THE DAY ❑ AT NIGHT W/PAIN

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- ❑ **HOUSEHOLD CHORES**
- ❑ **SITTING**
- ❑ **STANDING**
- ❑ **WALKING**
- ❑ **BENDING**
- ❑ **STOOPING**
- ❑ **LIFTING**
- ❑ **SNEEZING**
- ❑ **COUGHING**
- ❑ **STRAINING**
- ❑ **REACHING**
- ❑ **TWISTING**
- ❑ **SLEEPING**
- ❑ **LOOKING UP**
- ❑ **LOOKING DOWN**
- ❑ **MOVEMENT**
- ❑ **REST**
- ❑ **LYING SUPINE**
- ❑ **DRIVING**
- ❑ **TYPING**
- ❑ **SCOOPING**
- ❑ **EXERCISE**
- ❑ **STAIR STEPPING**
- ❑ **OTHER:** _____

WHAT RELIEVES YOUR SYMPTOMS?

- ❑ **SITTING**
- ❑ **STANDING**
- ❑ **LYING DOWN**
- ❑ **LEANING AGAINST A SUPPORT**
- ❑ **NO MOVEMENT OCCURS**
- ❑ **MOVEMENT OCCURS**
- ❑ **HEAT IS APPLIED**
- ❑ **ICE IS APPLIED**
- ❑ **REST OCCURS**
- ❑ **IBUPROFEN IS TAKEN**
- ❑ **MEDICATION IS USED**
- ❑ **ANALGESIC TOPICAL PAIN RELIEF GEL IS APPLIED**
- ❑ **STRETCHING/EXCERCISE IS USED**
- ❑ **SPINAL ADJUSTMENTS**
- ❑ **OTHER:** _____

SINCE YOUR COMPLAINT STARTED, HOW MUCH HAS PAIN INTERFERED WITH YOUR NORMAL WORK (INCLUDING BOTH WORK OUTSIDE THE HOME AND HOUSEWORK) :

❑ ALL THE TIME ❑ MOST OF THE TIME ❑ SOME OF THE TIME ❑ A LITTLE OF THE TIME ❑ NONE OF THE TIME

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS...

❑ EXCELLENT ❑ VERY GOOD ❑ GOOD ❑ FAIR ❑ POOR

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? (IF YES WHO ? AND THE DATE OF LAST VISIT)_____

_____

WHO HAVE YOU SEEN FOR YOUR CURRENT COMPLAINT?

❑ NO ONE

❑ CHIROPRACTOR (LIST NAME(S) AND TREATMENT RECEIVED)_____

_____

❑ MEDICAL DOCTOR (LIST NAME(S) AND TREATMENT RECEIVED)_____

_____

❑ ORTHOPEDIC/NEUROSURGEON (LIST NAME(S) AND TREATMENT RECEIVED)_____

_____

❑ PHYSCIAL THERAPIST (LIST NAME(S) AND TREATMENT RECEIVED)_____

_____

❑ OTHER (LIST NAME(S) AND TREATMENT RECEIVED)_____

_____

WHAT TESTS HAVE YOU HAD FOR YOUR SYMPTOMS? ❑ NONE

❑ X-RAYS: WHEN?_____ ❑ CT SCAN: WHEN?_____

❑ MRI: WHEN?_____ ❑ OTHER: WHEN?_____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ❑ YES ❑ NO IF YES, WHEN?

IF YOU HAVE SOUGHT TREATMENT IN THE PAST FOR THE SAME OR SIMILAR SYMPTOMS, WHO DID YOU SEE?

❑ THIS OFFICE ❑ OTHER CHIROPRACTOR ❑ MEDICAL DOCTOR ❑ PHYSICAL THERAPIST

❑ OTHER: _____

IF YOU ARE EXPERIENCING HEADACHES, PLEASE FILL OUT THIS SECTION:

WHERE IS THE PAIN ASSOCIATED WITH YOUR HEADACHES LOCATED?

	RIGHT SIDE	LEFT SIDE
SIDE OF HEAD		
BEHIND EYE		
FRONTAL		
BASE OF SKULL		
JAW JOINT		

ON WHAT DATE DID YOUR HEADACHES BEGIN?

DATE: _____/_____/_____ SAME AS NECK/BACK COMPLAINTS

WHAT IS THE INTENSITY OF YOUR HEADACHES?

1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

WHAT DESCRIBES YOUR PAIN?

❑ DULL ❑ SHARP ❑ ACHING ❑ DEEP

❑ STABBING ❑ BURNING ❑ VICE-LIKE

❑ THROBBING/PULSATING ❑ OTHER_____

WHEN DO YOUR HEADACHES USUALLY START?

❑ WAKING IN THE MORNING ❑ DURING THE EVENING

❑ AT MID-DAY ❑ CONSTANT

WHAT SEEMS TO BRING ON YOUR HEADACHES?

❑ PHYSICAL ACTIVITY ❑ CAFFEINE ❑ CERTAIN FOODS

❑ EXCESSIVE STRESS ❑ ALCOHOL

❑ MENSTRUAL PERIOD ❑ OTHER_____

HOW OFTEN DO THEY OCCUR?

_____X/WEEK _____X/MONTH

HOW LONG DO YOUR HEADACHES LAST?

❑ < 1 HR ❑ 1-3 HRS ❑ > 3 HRS ❑ ALL HRS

❑ SEVERAL HOURS ❑ OTHER

DO YOUR HEADACHES WAKE YOU? ❑ YES ❑ NO

DO THE FOLLOWING OCCUR WITH YOUR HEADACHES?

❑ NAUSEA/VOMITING ❑ WEAKNESS ❑ TREMOR

❑ LIGHT/SOUND SENSITIVE ❑ DIZZINESS ❑ VISION PROBLEM

❑ OTHER_____

WHAT MAKES YOUR HEADACHES BETTER?

❑ ICE/COLD PACKS ❑ REST ❑ LYING DOWN

❑ NSAIDS (ASPIRIN, TYLENOL) ❑ MASSAGE ❑ STANING

❑ NOTHING ❑ OTHER

MEDICAL CONDITIONS

❑ ARTHRITIS	❑ HYPERTENSION
❑ CANCER TYPE_____	❑ PSYCHIATRIC ILLNESS
❑ DIABETES	❑ SKIN DISORDER
❑ HEART DISEASE	❑ STROKE

SURGERIES

❑ APPENDECTOMY	❑ JOINT REPLACEMENT
❑ CARDIOVASCULAR PROCEDURE	❑ CERVICAL DISC PROCEDURE
❑ LAMINECTOMIES	❑ HYSTERECTOMY
❑ RADICAL PROSTATECTOMY	❑ TRANSURETHRAL PROSTATE
❑ OTHER (DESCRIBE): _____	

ALLERGIES

❑ EGGS	❑ SOY
❑ FISH AND SHELLFISH	❑ SULFITES
❑ MILK OR LACTOSE	❑ WHEAT/GLUTEN
❑ PEANUT	❑ OTHER:_____

SOCIAL HISTORY

❑ CAFFEINE USED OCCASIONALLY	❑ CAFFEINE USED OFTEN
❑ CHEW TOBACCO OCCASIONALLY	❑ CHEW TOBACCO OFTEN
❑ DRINK ALCOHOL OCCASIONALLY	❑ DRINK ALCOHOL OFTEN
❑ EXERCISE NOT AT ALL	❑ EXERCISE OCCASIONALLY
❑ EXERCISE OFTEN	❑ EXPERIENCE STRESS OCCASIONALLY
❑ EXPERIENCE STRESS OFTEN	❑ SMOKE 1 PACK OR LESS PER DAY
❑ SMOKE MORE THAN 1 PACK A DAY	❑ WEAR SEAT BELTS ALWAYS
❑ WEAR SEAT BELTS NEVER	❑ WEAR SEAT BELTS USUALLY

SUBSTANCE ABUSE

❑ ALCOHOL (PAST)	❑ ALCOHOL (PRESENT)
❑ AMPHETAMINES (PAST)	❑ AMPHETAMINES (PRESENT)
❑ BARBITUATES (PAST)	❑ BARBITUATES (PRESENT)
❑ COCAINE (PAST)	❑ COCAINE (PRESENT)
❑ CRYSTAL METH (PAST)	❑ CRYSTAL METH (PRESENT)
❑ HEROINE (PAST)	❑ HEROINE (PRESENT)
❑ MARIJUANA (PAST)	❑ MARIJUANA (PRESENT)

OCCUPATIONAL ACTIVITIES

❑ BUSINESS OWNER	❑ COMPUTER/ADMINISTRATIVE
❑ EXECUTIVE/LEGAL	❑ FOOD SERVICES
❑ HEALTHCARE/HOMESERVICE	❑ CONSTRUCTION/LABORER
❑ HOUSEHOLD	❑ OTHER:_____

RECREATIONAL ACTIVITIES

❑ BACKPACKING	❑ BOATING
❑ GOLF	❑ RUNNING
❑ SOCCER	❑ TENNIS
❑ WEIGHT LIFTING	❑ FOOTBALL
❑ BIKING	❑ SKIING
❑ RACKET BALL	❑ WALKING
❑ SWIMMING	❑ OTHER:_____

WOMEN ONLY

ARE YOU PREGNANT? ❑ NO ❑ YES DUE DATE:_____	
IF PREGNANT IN PAST, WERE PREGNANCIES NORMAL? ❑ YES ❑ NO	
ARE YOU SEEING AN OB-GYN REGULARLY? ❑ YES ❑ NO	
# OF BIRTHS	DATE OF LAST EXAM:
PHYSICIAN'S NAME & ADDRESS:	

HAVE YOU EVER HAD A SERIOUS ACCIDENT/INJURY? ❑ YES ❑ NO (LIST, DATE, AND DESCRIBE)

ARE YOU CURRENTLY TAKING ANY VITAMINS, MINERALS, OR HERBS? ❑ YES ❑ NO (PLEASE LIST)

Ottawa Chiropractic Clinic, P.A.
1501 S. Main, Ottawa, KS 66067

REVIEW OF SYSTEMS

HAVE YOU HAD TROUBLE WITH ANY OF THE FOLLOWING?

CARDIOVASCULAR

	PRESENT	PAST
POOR CIRCULATION		
HIGH BLOOD PRESSURE		
AORTIC ANEURYSM		
HEART DISEASE		
HEART ATTACK		
CHEST PAIN		
HIGH CHOLESTEROL		
PACE MAKER		
JAW PAIN		
IRREGULAR HEARTBEAT		
SWELLING OF LEGS		

GENITOURINARY

	PRESENT	PAST
KIDNEY DISEAS		
LOWER SIDE PAIN		
BURNING URINATION		
FREQUENT URINATION		
BLOOD IN URINE		
KIDNEY STONE		

HEMATOLOGIC/LYMPHATIC

	PRESENT	PAST
HEPATITIS		
BLOOD CLOTS		
CANCER		
EASY BRUISING		
EASY BLEEDING		
FEVERS/CHILLS/SWEATS		

RESPIRATORY

	PRESENT	PAST
ASTHMA		
TUBERCULOSIS		
SHORTNESS OF BREATH		
EMPHYSEMA		
COLD/FLU		
COUGH/WEEZING		
BRONCHITIS		
PNEUMONIA		

EARS/NOSE/THROAT

	PRESENT	PAST
DIZZINESS		
HEARING LOSS		
SINUS INFECTION		
NOSEBLEED		
SORE THROAT		
DIFFICULTY SWALLOWING		
BLEEDING GUMS		
EAR INFECTION		

EYES

	PRESENT	PAST
GLAUCOMA		
DOUBLE VISION		
BLURRED VISION		

INTEGUMENTARY

	PRESENT	PAST
SKIN ULCERS		
SKIN DISEASE		
ECZEMA		
PSORIASIS		
RASHES		

ALLERGIC/IMMUNOLOGIC

	PRESENT	PAST
HIVES		
IMMUNE DISORDER		
HIV/AIDS		
ALLERGY SHOTS		
ALLERGY MEDS		
CORTISONE USE		

GASTROINTESTINAL

	PRESENT	PAST
GALLBLADDER PROBLEMS		
BOWEL PROBLEMS		
CONSTIPATION		
LIVER PROBLEMS		
ULCERS		
DIARRHEA		
NAUSEA/VOMITING		
POOR APPETITE		

MUSCULOSKELETAL

	PRESENT	PAST
GOUT		
ARTHRITIS		
JOINT STIFFNESS		
MUSCLE WEAKNESS		
OSTEOPOROSIS		
BROKEN BONES		
JOINTS REPLACED		

ENDOCRINE

	PRESENT	PAST
THYROID DISEASE		
DIABETES		
HAIR LOSS		
MENOPAUSAL		
MENSTRUAL PROBLEMS		

PSYCHIATRIC

	PRESENT	PAST
DEPRESSION		
ANXIETY DISORDER		
UNUSUAL STRESS		

CONSTITUTIONAL

	PRESENT	PAST
WEIGHT LOSS/GAIN		
ENERGY LEVEL PROBLEM		
DIFFICULTY SLEEPING		

NEUROLOGICAL

	PRESENT	PAST
STROKE		
SEIZURES		
HEAD INJURY		
BRAIN ANEURYSM		
NUMBNESS		
SEVERE HEADACHES		
PINCHED NERVES		
PARKINSONS DISEASE		
CARPAL TUNNEL		
SPINNING/BALANCE		

FAMILY HISTORY

CHECK APROPRIATE BOXES IF THEY AFFECTED THAT PERSON

	FATHER	MOTHER	BROTHERS	SISTERS	CHILDREN
ANEMIA					
ARTHRITIS					
BACK/DISC PROBLEMS					
CANCER					
CHOLESTEROL					
CONGENITAL DEFECTS					
DIABETES					
GENETIC DISEASE					
HEADACHES					
HEART TROUBLE					
HIGH BLOOD PRESSURE					
JOINT PROBLEMS					
KIDNEY DISEASE					
MENTAL ILLNESS					
MULTIPLE SCLEROSIS					
OSTEOPOROSIS					
PHSYCHIATRIC					
SCOLIOSIS					
STROKE					
THYROID					
DECEASED					
OTHER:_____					

DOCTOR'S NOTES_____

RELEASE OF INFORMATION

I _____ give permission to the staff at Ottawa Chiropractic Clinic, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI)		NAME: (LAST, FIRST, MI)	
RELATIONSHIP:		RELATIONSHIP:	
ADDRESS:		ADDRESS:	
CITY	STATE: ZIP:	CITY:	STATE: ZIP:
PHONE:		PHONE:	

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all 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 me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

***Ownership of X-ray Films**: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental, and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, 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 subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

SIGNATURE:	**DATE:**
WITNESS SIGNATURE:	**DATE:**
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	**DATE**

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ **PATIENT** ❑ **SPOUSE** ❑ **PARENT** ❑ **WORKERS COMP** ❑ **AUTO INSURANCE** ❑ **MEDICARE** ❑ **HEALTH INSURANCE**