

# Patient Information

Personal Information	
Name:	
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
E-mail:	
Employer:	
Date of Birth:	Age:
Marital Status:	
Spouse's Name:	
Number of Children:	
Names / Ages:	

Previous Chiropractic Experience
Have you previously received Chiropractic Care? Yes / No
Doctor's Name:
Date of Last Visit:
Were you pleased with your results: Yes / No
Who Referred You to Our Office?
Is there anyone you would like us to contact about Wellness?

Stress Information	
On a scale of 1-10 (10 being the Most) describe your:	
Physical Stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)	
Chemical Stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)	
Mental / Emotional Stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)	
On a scale of Poor - Good - Excellent , describe your:	
Diet:	Exercise:
Sleep:	General Health:

A Little About Your Health
We will soon address your main reason for coming to our office, but we would first like to get some information about your lifestyle.
What medications are you taking?
What surgeries have you had?
Do you exercise? Yes / No How often?
How much water do you drink daily?
What are you drinking daily?
Do / Did you smoke? Yes / No How much?
Do / Did you drink alcohol? Yes / No How often?
How is your digestion? <span style="float: right;">IBS / Acid Reflux</span>
Do you have Blood Pressure Problems? Yes / No
Do you have Heart Problems? Yes / No Asthma? Yes / No



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### For Office Use Only

<b>Member ID:</b>	<b>Group:</b>	<b>Phone #:</b>	<b>Ref: Y / N</b>
<b>Effective Date:</b>	<b>Ded:</b>	<b>Family:</b>	<b>Met: Calendar Yr / Contract Yr</b>
<b>Office Visit:</b>	<b>X-rays Included? Y / N</b>	<b>% Cov:</b>	<b>Max Per Year: (PV) Met (\$)</b>

**Terms of Acceptance**

When a patient seeks Chiropractic Wellness care and we accept a patient for such care, it is essential for us both to be working toward the same objective. Chiropractic Wellness has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. The foundation of our Chiropractic Wellness method of correction is by specific adjustment of the spine. **Health:** A state of consistent homeostatic cell function. **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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 examination 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 another health care provider.

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 methods are specific adjusting to correct vertebral subluxation, nutritional recommendations and mental/emotional strategies.

I, \_\_\_\_\_, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept Chiropractic Wellness care on this basis. Initials \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Evaluate and Adjust a Minor**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a Chiropractic Wellness examination, which may include x-rays if necessary, and Chiropractic Wellness Care.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**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:

- 1) Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- 2) Obtain payment from third party payers.
- 3) 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.

Name (Please Print) \_\_\_\_\_ Signed \_\_\_\_\_ 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 \_\_\_\_\_. Initials \_\_\_\_\_