THE ROCK HEALTH & WELLNESS CENTERS
Date_____
Front and Back Please

Patient Information

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

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? IBS / Acid Reflux
Do you have Blood Pressure Problems? Yes / No
Do you have Heart Problems? Yes / No Asthma? Yes / No
Have you been diagnosed with Diabetes? Yes / No Type: 1 or 2

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?

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)

About You
How would you describe your health? Poor / Good / Excellent
Do you live On Purpose? Yes No
Have you ever wanted to be Great? Yes No
Would you like to be healthier? Yes No

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For Office Use Only Ins Co: _____ Spoke with _____ Date _____ Initials _____

Member ID:		**Group:**		**Phone #:**		**Ref: Y / No**
Effective Date:	**Pre Ex: Y / N**	**Ded:**	**Family:**	**Met:**		**Calendar Yr / Contract Yr**
Office Visit:	**X-rays? Y / N**	**% Cov:**	**PT:**	**MT:**	**Max Per Year: (PV)**	**($)**

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.

Health: A state of consistent homeostatic cell function. *Subluxation:* A misalignment of one or more of the 24 vertebrae in the spinal column, the bones of the pelvis, extremities, occiput or temporomandibular joint, which causes alteration of nerve function and interference in the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. *Adjustment:* the specific application of forces to facilitate the body's correction of subluxation. Although the foundation of our Chiropractic Wellness Care, the correction of subluxation, is done by specific adjustment to the spine, we also incorporate other modalities including, but not limited to, spinal tractioning, postural exercises, therapeutic exercises, massage, nutritional education, and mental/emotional strategies for health.

We do not offer to diagnose or treat any disease or condition other than 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.

I,_____, have read and fully understand the above statements. I have also been given a copy of the Consent for Purpose of Treatment brochure. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. 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_____

THE ROCK HEALTH & WELLNESS CENTERS
Name _____
Date _____

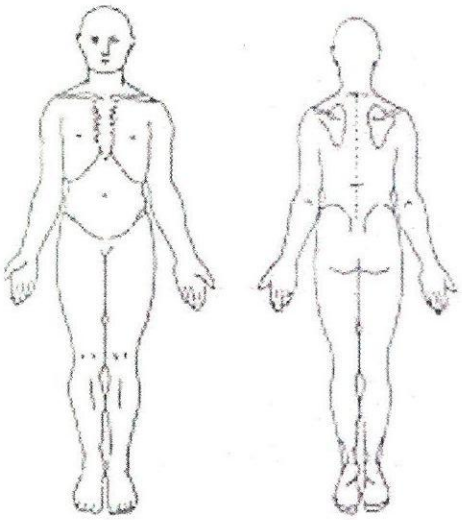
Reason for Seeking Care

Primary Reason You are Here? _____

When did this problem start? Date: _____ **How did it start? (circle)** Gradual Sudden Progressive

Have you had this problem before? Yes / No **Date of the first occurrence:** _____

Have you seen any other Doctors for this problem? Yes No **If yes, Who?** _____



Place the letter of the complaint on the diagram to indicate your perceived area of malfunction.

Pain (P)
Tingling (T)
Numbness (N)
Burning (B)
Stiffness (S)
Notes:

Severity of Problem:
On a scale of 1-10
1 2 3 4 5 6 7 8 9 10
Best Worst

_____
_____

Site (circle) Local or Radiates (from _____ to _____)
Is the Problem (circle) Constant Frequent Intermittent Occasional
Character of Problem: Dull/Ache Sharp/Stabbing Burning Numb/Tingling Throbbing other; explain_____

Relieving Factors: Rest Exercise Sitting Standing Lying Down Hot Packs Cold Packs Other _____

Aggravating Factors: Coughing Sneezing Lifting Bending Driving Sitting Standing Walking Running
Other_____

Secondary Problem: _____

When did this problem start? Date: _____ **How did it start? (circle)** Gradual Sudden Progressive

Have you had this problem before? Yes / No **Date of the first occurrence:** _____

Have you seen any other Doctors for this problem? Yes No **If yes, Who?** _____

Site: Local or Radiates (from _____ to _____)**Is the Problem (circle)** Constant Frequent Intermittent Occasional

Character of Problem: Dull/Ache Sharp/Stabbing Burning Numb/Tingling Throbbing other; explain_____

Relieving Factors: Rest Exercise Sitting Standing Lying Down Hot Packs Cold Packs Other _____

Aggravating Factors: Coughing Sneezing Lifting Bending Driving Sitting Standing Walking Running
Other_____

Extremities

Do you have any problems with your: **Shoulders:** Right / Left **Elbows:** Right / Left **Wrists:** Right / Left
Hips: Right / Left **Knees:** Right / Left **Ankles:** Right / Left
TMJ: Right / Left

Are there any other issues you would like us to address?

_____
_____

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