

*Section I: Personal information*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Age:\_\_\_\_\_\_

 First MI Last

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Cell Work

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ****Male****Female

****Single ****Married ****Divorced ****Widowed Spouse’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer and Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Repetitive motions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past chiropractic care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Section II: Lifestyle and Social History*

Please 🗹 if the following apply to you

|  |  |  |
| --- | --- | --- |
| **** | Use tobacco products (chewing tobacco) \_\_\_PPD for \_\_\_\_\_ years |  |
| **** | Drink alcohol | Abstainer Light Moderate Binge Heavy drinker Former Alcoholic |
| **** | Exercise | Sedentary Light Moderate Vigorous |

*Section III: Medications and/or supplements*

List any medications or supplements (prescription and/or over the counter) you are taking and the reason for them. ****None

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Section IV: Family Health History*

Please provide the health history of your immediate family members.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relative** | **Health State** | **Illnesses** | **Age at death** | **Cause of death** |
| **Good** | **Poor** |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Sibling |  |  |  |  |  |
| Sibling |  |  |  |  |  |

Previous Surgeries/hospitalizations (including date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any fractures or broken bones (Including date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been in a motor vehicle accident? ****Yes ****No If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Section V: Reason for seeking care*

List any symptoms you experiencing today: (i.e. neck pain, headache, low back pain, etc.)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1)very mild (2) (3) (4) (5) (6)(7) (8) (9)(10) VERY severe

Frequency of pain: constantfrequent intermittentnone

Type of pain: achy dull burning sharp shooting stabbing throbbingtingling

 Pain is getting: improved  same worse chronic

 Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date when symptoms started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1)very mild (2) (3) (4) (5) (6)(7) (8) (9)(10) VERY severe

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 Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date when symptoms started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Section VI: Personal health history*

Review of systems: please 🗹 indicating if this issue represented applies to you. ****None of these issues apply

|  |
| --- |
| **Musculoskeletal** |
| Arthritis | **** | Knee problem | **** | TMJ pain | **** |
| Osteoporosis | **** | Ankle/foot problem | **** | Sciatic pain | **** |
| Scoliosis | **** | Mid back pain | **** | Shoulder problem | **** |
| Neck pain | **** | Elbow/hand problem | **** | Low back pain | **** |
| **Neurological** |
| Headaches | **** | Dizziness | **** | Depression/Anxiety | **** |
| ADD/ADHD | **** | Numbness/tingling | **** | Seizures/tremors | **** |
| **Cardiovascular** |
| High blood pressure | **** | High cholesterol | **** | Pacemaker | **** |
| Leg pain with walking | **** | Heart Attack | **** | Stroke | **** |
| **Respiratory** |
| Asthma | **** | Difficulty breathing | **** | COPD | **** |
| **Digestive** |
| Food sensitives | **** | Acid reflux | **** | Heart burn | **** |
| **Skin** |
| Eczema | **** | Rash | **** | Psoriasis | **** |
| **Genitourinary** |
| Kidney stones | **** | Frequent urination | **** | Hesitancy | **** |
| Menstrual | **** | Prostate | **** | Pregnancy  | **** |
| **Endocrine** |
| Thyroid problems | **** | Diabetes | **** | Immune disorder | **** |
| **Infectious disease** |
| Hepatitis | **** | Tuberculosis | **** | HIV | **** |
| **Cancer**  | ****Type: |  |  | OTHER |  |

**Healthcare Authorization and Notice of Privacy Policy**

**Notice of Privacy Practices**

* The Notice of Privacy Practices attached is for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created/received by this office. I have received a copy of the Notice of Patient Privacy Policy.

**Revocation of Consent**

* You may revoke this consent to the use and disclosure ofyour PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Use and Disclosure of your Protected Health Information**

* Your PHI will be used by One Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Treatment is provided in a closed room, but I am aware that other persons in the office may overhear some of my PHI during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

One Chiropractic is currently in network with most insurance companies, and payment is due at time of service. It is understood by my signature below that I have been notified of my financial obligation. In the event that my account becomes untimely, a 30% fee may be added and any pay-at-time of discounts will be removed. I understand that I am financially responsible for all charges whether or not paid by the insurance company.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   |  |  |  |  |  |
| Patient or Legally Authorized Individual Signature |  | Date |  |
|  |  |  |  |
| Print Patient’s Full Name |  | Social Security Number |

**Consent for Chiropractic Care**

* Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health. Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
* A chiropractic examination will be performed which may include: spinal and physical examination, orthopedic and neurological testing, palpation, and radiological examination (x-rays).
* The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.
* In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.
* Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process
* The availability and nature of other treatment options may include the following self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers and hospitalization/surgery.
* I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.
* I have read the above paragraphs and understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize One Chiropractic to proceed with chiropractic care and treatment. I further understand that the fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also understand that I shall be personally liable for any and all of the unpaid balance to the doctor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/parent Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature Date