

Thank you for taking time to fill out the following forms. Our mission is to provide the highest quality of Chiropractic care, educate our community on the importance of lifetime Chiropractic care, as well as provide the best customer service to give each practice member the experience and results they deserve.

We are honored you are here. Our team will take amazing care of you & your family!

**BASICS**

Legal Name: \_\_\_\_\_ Nickname (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Gender: Male Female Email Address: \_\_\_\_\_

If you plan to file insurance, please provide the policy holders full name \_\_\_\_\_ and your relationship to the policy holder: (please circle) SELF SPOUSE DEPENDENT

\*\*Who may we thank for referring you? \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Best contact number: \_\_\_\_\_

**WHAT BRINGS YOU HERE?**

People seek Chiropractic care for a variety of reasons depending on personal needs, expectations, perceptions, and past experiences. We want to do our best to understand what brings you here so that our team can meet your specific needs. Please check those that apply to you:

**RELIEF CARE**

- Pain reduction
- Crisis Management
- Symptom relief
- Stress reduction

**CORRECTIVE CARE**

- Improved function
- Increased strength
- Improved movement
- Improved performance

**HOLISTIC CARE**

- Improved quality of life
- Improved immune system function
- Optimum nervous system function
- Prevention &/or Longevity

**OTHER**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.'s initials: \_\_\_\_\_

**CHIEF COMPLAINT**

Chief Complaint #1: \_\_\_\_\_

When did it start? \_\_\_\_\_ What happened? \_\_\_\_\_

What daily activity(ies) is this affecting? \_\_\_\_\_

Since the onset, is the condition:  Improving  Worse  Same

Please rate your pain on a scale of 0 to 10 for complaint #1 (0 is no pain, 10 is extreme pain): \_\_\_\_\_

**Describe complaint #1 in more detail:**

How **often** do you experience your symptoms:  Constantly (76-100%)  Frequently (51-75%)  
 Occasionally (26-50%)  Intermittently (1-25%)

What is the **quality** of your complaint:  Sharp  Stabbing  Burning  Achy  Dull  Stiff & Sore

Your complaint **improves with**:  Ice  Heat  Movement  Stretching  Sleep/Rest  OTC Meds

Your complaint is **worse with**:  Sitting  Standing  Walking  Lying down  Lifting  Overuse

Chief Complaint #2: \_\_\_\_\_

When did it start? \_\_\_\_\_ What happened? \_\_\_\_\_

What daily activity(ies) is this affecting? \_\_\_\_\_

Since the onset, is the condition:  Improving  Worse  Same

Please rate your pain on a scale of 0 to 10 for complaint #1 (0 is no pain, 10 is extreme pain): \_\_\_\_\_

**Describe complaint #2 in more detail:**

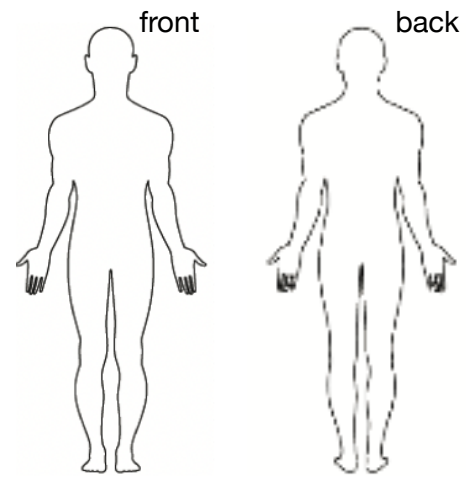
How **often** do you experience your symptoms:  Constantly (76-100%)  Frequently (51-75%)  
 Occasionally (26-50%)  Intermittently (1-25%)

What is the **quality** of your complaint:  Sharp  Stabbing  Burning  Achy  Dull  Stiff & Sore

Your complaint **improves with**:  Ice  Heat  Movement  Stretching  Sleep/Rest  OTC Meds

Your complaint is **worse with**:  Sitting  Standing  Walking  Lying down  Lifting  Overuse

**Use the figure to the right and place an "X" to indicate the specific areas you are experiencing pain, discomfort, or limited range of motion.**



**Health Information Consent & Terms of Acceptance**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**Pregnancy Release:** This is to certify that to the best of my knowledge I am not pregnant and the above doctor has 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 period: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I have read and understand how my Patient Health Information will be used  
and I agree to these policies and procedures.**

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For further information regarding this notice, please contact our Doctors at (405)-478-1507**