PHONE: 405-216-3293
FAX: 405-216-3352

ONE HEALTH

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 customerservice 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 circle those that apply to you or state other:

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

Optimum nervous system

OTHER

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:

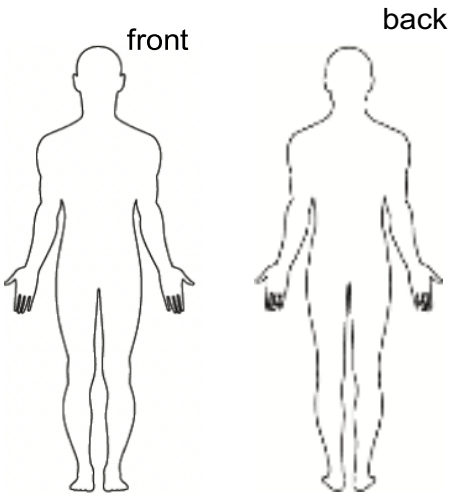
How **often** do you experience your symptoms: __ Constantly (76-100%) __Frequently (51-75%)
__ Occasionally (26-50%) __ Intermittently (1-25%)

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.



Patient Name (please print): _____

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 have 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/Guardian:_____ Date: _____

For further information regarding this notice, please contact our office at (405)216-3293