



We would like to get to know you better

Date _____

Name _____ Male Female Single Married Other

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer _____ Work Phone _____

Social Security Number _____ Date of Birth _____ Referred by: _____

Do you have children? _____ What are their names and ages? _____

Spouse's Name _____ Occupation _____

Have they or any other members of your family received chiropractic care? Yes No

Have you ever had chiropractic care? Yes No How long has it been? _____

The purpose or reason for this appointment? _____

For Insurance Purposes:

Name of Insurance Carrier _____ Policy Number _____

Phone Number _____

Name of Cardholder _____ Cardholder's Date of Birth _____

Cardholder's Social Security Number _____ Cardholder's Employer _____

Are you covered by another plan? _____ If yes, name of carrier _____

Medical History:

Do you have any allergies? (Specify): _____

How often do you drink alcoholic beverages? _____

Do you smoke? Yes No How much? _____ Do you exercise? Yes No How often? _____

Have you ever suffered from or been diagnosed as having: (Circle YES or NO for each)

- | | | |
|--------------------------------|---------------------|---------------------|
| Y N *Broken or Fractured Bones | Y N *Osteoarthritis | Y N Eating Disorder |
| Y N Circulatory Problems | Y N Epilepsy | Y N Alcoholism |
| Y N *Rheumatoid Arthritis | Y N Pacemaker | Y N Drug Addiction |
| Y N Seizures/Convulsions | Y N Strokes | Y N HIV Positive |
| Y N A Congenital Disease | Y N *Cancer | Y N Gall Bladder |
| Y N Excessive Bleeding | Y N Ulcers | Y N *Head Problems |
| Y N High/Low Blood Pressure | Y N Ruptures | Y N Depression |
| Y N *Diabetes | Y N Coughing Blood | Y N Tumors |

*Explanation:

List any medications you are taking at this time: _____

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please circle the **severity** of your **main complaint** (At it's worst)

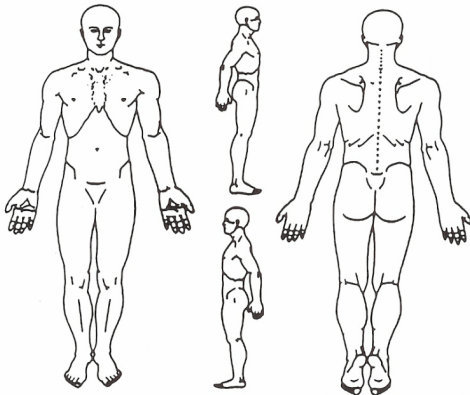
<i>None</i>	<i>Slight</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>					
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle the **percentage of time** you experience your main complaint.

<i>Occasional</i>	<i>Intermittent</i>	<i>Frequent</i>	<i>Constant</i>						
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

4. How **long** have you been experiencing your **main complaint**? _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



Do you have pain and/or difficulty performing any of the following activities? (check please)

_____ personal care

_____ lifting

_____ reading

_____ concentrating

_____ work

_____ driving

_____ sleeping

_____ recreation

_____ walking

_____ sitting

_____ standing

_____ social life

Signature: _____

Date: _____

6. When do you notice it most? _____ AM _____ PM
How long does it last? _____ Mins _____ Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have _____ been hospitalized _____ been treated by another chiropractor
_____ been treated by another specialty provider _____ never received care for this problem.
11. Have you lost time from work because of it? Yes No
Dates? _____ To _____
12. Are you Pregnant? Yes No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

DATE: _____

ACCT: _____

PATIENT: _____

SYSTEMS REVIEW

In the left hand column, please indicate with a (C) **Conditions you now have** or with a (P) the conditions you have had **in the Past**. If either apply, mark (NA), don't leave any blanks.

<p>_____ High Blood Pressure</p> <p>_____ Dizziness/ Fainting</p> <p>_____ Insomnia</p> <p>_____ Low Resistance</p> <p>_____ Tension</p> <p>_____ Confusion</p> <p>_____ Fatigue</p> <p>_____ Ulcers</p> <p>_____ Eye/ Vision Problems</p> <p>_____ Ear/ Hearing Problems</p> <p>_____ Difficulty Breathing</p> <p>_____ Heart Problems</p> <p>_____ Loss of Bladder control</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Digestion Problems</p> <p>_____ Nausea</p> <p>_____ Female Problems</p> <p>_____ Prostate Problems</p> <p>_____ Diabetes</p> <p>_____ Hands/ Feet Cold</p> <p>_____ Loss of Memory</p> <p>_____ Nervousness</p> <p>_____ Sweaty Palms</p> <p>_____ Speech Difficulty</p> <p>_____ Anxiety</p> <p>_____ Depression</p> <p>_____ Irritability</p>	<p style="text-align: center;">FOR DOCTOR'S USE ONLY</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 15%;">DR. 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<p>Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your present problem(s)</p> <p style="text-align: center;">PROBLEM LIST</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">DR. NAME/ FACILITY</th> <th style="width: 20%;">PROBLEM</th> <th style="width: 30%;">TYPE OF TREATMENT RECEIVED</th> <th style="width: 30%;">FROM WHEN TO WHEN</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				DR. NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECEIVED	FROM WHEN TO WHEN																																	<p style="text-align: center;">FOR DOCTOR'S USE ONLY</p> <p style="text-align: center;"><u>ONLY</u></p> <p>Reviewed External H P</p> <p>Release Records H P</p> <p>Request Records H P</p> <p>External Dx'd _____</p> <p>_____</p> <p>Disabilities:</p> <p>_____</p> <p>Impairments:</p> <p>_____</p>
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TERMS OF ACCEPTANCE

1. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic 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 force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above
(print name)
statement and accept chiropractic care on this basis.

(signature)

(date)

2. CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission of my child to receive chiropractic care.

(signature)

(date)

3. PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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 period: _____

(signature)

(date)

Chiropractic Insurance Policy

- 1) All first visit charges are payable when services are rendered.
- 2) Our office is set up to utilize direct payment from insurance companies. This is done as a courtesy to our patients and there is no charge for this service. However, it is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. We expect payment in full when the services are rendered until your insurance coverage has been verified.

Patient Signature

Date

Guardian's Signature Authorizing Care for Minor

Date



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Janet Sei
Telephone: (623) 551-9100
FAX: (623) 551-9103
Address: 42104 N. Venture Court, Bldg, E. Anthem, AZ 85086

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please print name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
But acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

