PATIENT INFORMATION - PLEASE COMPLETE ALL SECTIONS:

Name : ____ Date: _______________

Age: ________ Birth Date: ________________ Male/Female Race: ____________

Marital Status: M S W D Student Status: Full Time/Part Time/Non-student

Home Phone: _________________ E-mail Address: ______________________________ Cell: ____________________

Address: _____________________________________ City: _________________ State: _______ Zip: ____________

What is your preferred method of contact? Circle one: Home/Cell/E-mail

Occupation: ____________________________________ Employer: ____

Spouse: _________________________ Occupation: _______________________ Employer: ______________________

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative: ___________________________________ Phone: __________________________________

Family Medical Doctor: _____________________________________ Phone: __________________________________

How were you referred to our office? Circle one: Friend Family CHS Website Online Local Event

Name: ____

FINANCIAL INFORMATION

*Insurance *Worker's Comp * Self-Pay (Cash) *Personal Injury/Auto *Auto *Other__________________________

PRIMARY INSURANCE:

Insurance Name: ________________________________

Insurance ID Number: ____________________________

Patient SSN# ___________________________________

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:

Insured's Name: ______________________ Gender: M/F

Insured SSN# __________________________________

Address: ______________________________________

City: ________________ State: ________ Zip: ________

Phone: ______________ Date of Birth: _______________

SECONDARY INSURANCE:

Insurance Name: ________________________________

Insurance ID Number: ____________________________

Patient SSN# ___________________________________

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:

Insured's Name: ______________________ Gender: M/F

Insured SSN# __________________________________

Address: ______________________________________

City: ________________ State: ________ Zip: ________

Phone: ______________ Date of Birth: _______________

It is our office policy to pay the day of services unless otherwise arranged.

Who is responsible for payment? Self/Other (relationship) - ____

Other than self:

Name: ____ Phone: ________________________________

Address: ____ City_________________ State ________ Zip __________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits be made to **Chiropractic Health Solutions** for the Services described on the insurance form. This authorization is to apply to all services received until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. I also authorize the release of any medical or other information necessary (PHI) to process my insurance claim. This is to serve as a long-term authorization card. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 40%. If you would like to have a more detailed of our policies and procedures concerning the privacy of you Protected Health Information (PHI) we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

Signature____ Date ___________________________________

CONSULTATION QUESTIONNAIRE

Describe your current problem and how it began: ____

____

Is this related to an auto or work accident? _________ Date of accident: ___________

How many days lost from work? ______________________

Have you ever had the same or a similar condition? ___ Yes ___ No If yes, when and describe _______________________

____

Has it become worse recently? ___ Yes ___ No ___ Circle one: Same/Better/Worse/Gradually Worse If yes, when and how: ____

What does this prevent you from doing or enjoying? ____

How long does it last? ____________ All Day ____________ Hours ___________ Minutes

Are there any other conditions or symptoms that may be related to your major symptom? ___ Yes ___ No

If yes, describe: ____

____

Have you seen any other provider for this condition? ___ Yes ___ No If yes, explain treatment or prognosis: ___________

____

Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint? ___Yes ___ No

If yes, date _________________ Area screened ____

HEALTH HISTORY

Date of last physical examination? ______________________

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? (Include dates) _________________________

____

Have you been treated for any health condition by a physician in the last year? ___ Yes ___ No

If yes, describe: ____

What medications or drugs are you taking? (Include vitamins): ____

____

Do you have any allergies to medications/ or other? ___ Yes ___ No If yes, explain: ________________________________

____

Do you have any congenital (present at birth) condition? ___ Yes ___ No If yes, describe: ___________________________

____

Women: Are you pregnant? _____________________ Due Date? _________________________

Women, please include information about childbirth (include dates): ____

____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it and provide frequency:

Exercise (please circle) None Daily Weekly Type of exercise (please circle) Walk Run Swim Other _____________

High stress activity __________________ Family Pressures ________________ Financial Pressures __________________

Other mental stress: ____

____

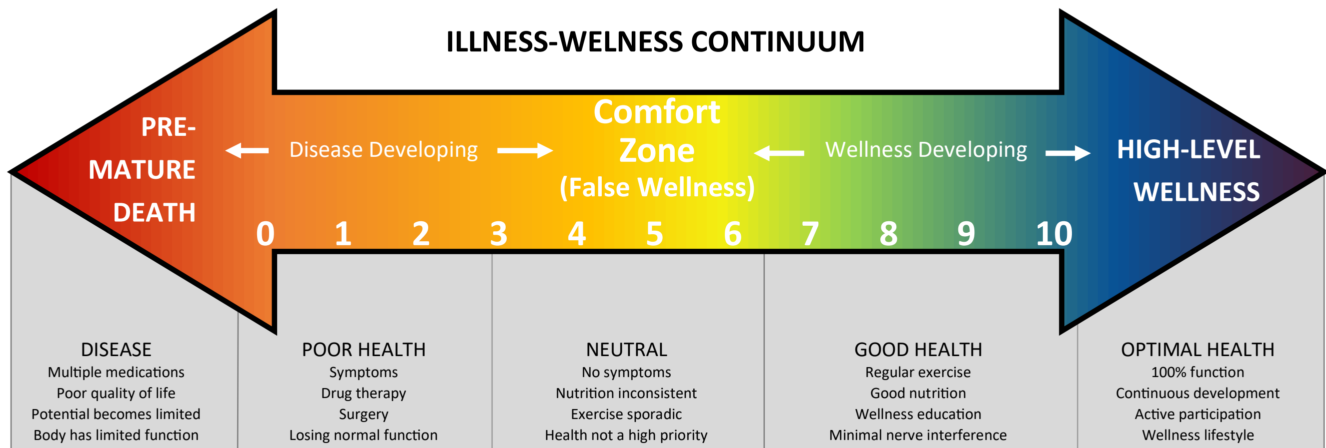
Alcohol Use (please circle) None Casual Moderate Heavy

Drug Use (please circle) None Recreational Addiction

Do you smoke? ___ Yes ___ No If yes, number of packs a day ____ Other tobacco use ____ Previous smoker? ________

Caffeinated drinks consumed per day (please circle): 0-3 3-6 6+

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? ______________________________

B. In what direction is your health currently headed? ______________________________

WHAT ARE YOUR HEALTH GOALS?

Immediate: ______________________________

____

Short Term (What do you have to do?): ______________________________

____

Long Term (What do you want to do?): ______________________________

____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other ______________	☐	☐	☐	☐

How committed are you to correcting this issue?

1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

I certify that the information provided is accurate to the best of m knowledge:

Print Patient Name: ____

Patient/Legal Guardian Signature: ____Date: _______________________

Right to Rescind:

This section is to attest that you understand your right to rescission as a patient at Chiropractic Health Solutions. You have the right to rescind payment within 72 hours of any services received above and beyond the discounted offer that you received. Due to legal restrictions, special offers are not available to all patients with state or federally funded healthcare plans such as Medicare.

Patient Signature: ____ Date: _______________________

INFORMED CONSENT

CHIROPRACTIC HEALTH SOLUTIONS

I will use my hands or mechanical instruments upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or “Spinal Adjustment.” As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, dislocations, Bernard-Horner’s Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to, stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of the adjustment.

I am aware of these complications, and in order to minimize their occurrences I will take precautions. These precautions include, but are not limited to, my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant or nursing, you should tell me when I take your clinical history.

Printed Name of Patient/Legal Guardian: ____

Signature of Patient/Legal Guardian: ____Date: ______________________