

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Sex: M F Marital Status: M S D W Date of Birth: _____ Age: _____

Social Security Number: _____

Occupation: _____

Employer: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, When: _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary Reason: _____

Secondary Reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems Lung problems/shortness of breath Cancer Diabetes
 Psychiatric disorders Bipolar disorder Major depression Schizophrenia
 Stroke/TIA's Other _____ None of the above

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

Patient Name: _____ **Date:** _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Type of surgery	Date
_____	_____
_____	_____
_____	_____

F. Females/Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

4. Family Health History:

Do you have a family history of any of the following? (please indicate all that apply)

- Cancer Stroke/TIA's Headaches Cardiac Disease Diabetes
- Neurological diseases Adopted/Unknown Cardiac disease below age 40
- Psychiatric disease Other None of the above

Deaths in Immediate Family:

Cause of parents/siblings death	Age at death
_____	_____
_____	_____
_____	_____

Patient Name: _____ **Date:** _____

Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

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Review of Symptoms

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries Congestive heart failure Murmurs of valvular disease Heart Attack/MI's
 Heart disease/problems Hypertension Pacemaker Angina/chest pain
 Irregular heartbeat Other _____ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures
 One-sided decreased feeling in the face or body Headaches Memory loss Tremors
 Vertigo Loss of sense of smell Strokes/TIA's Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** issues?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes
 Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones hematuria (blood in the urine) Incontinence (cant control)
 Bladder infections Difficulty urinating Kidney disease Dialysis Other _____
 None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty Swallowing Ulcerative disease Frequent abdominal pain
 Hiatal Hernia Constipation Pancreatic disease Irritable bowel/colitis
 Hepatitis or liver disease Bloody or black tarry stool Vomiting blood Bowel incontinence
 Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxin/Aleve) HIV Positive
 Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
 Hyper coagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy
 Regular aspirin use Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grates Psoriatic disorders
 Other _____ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

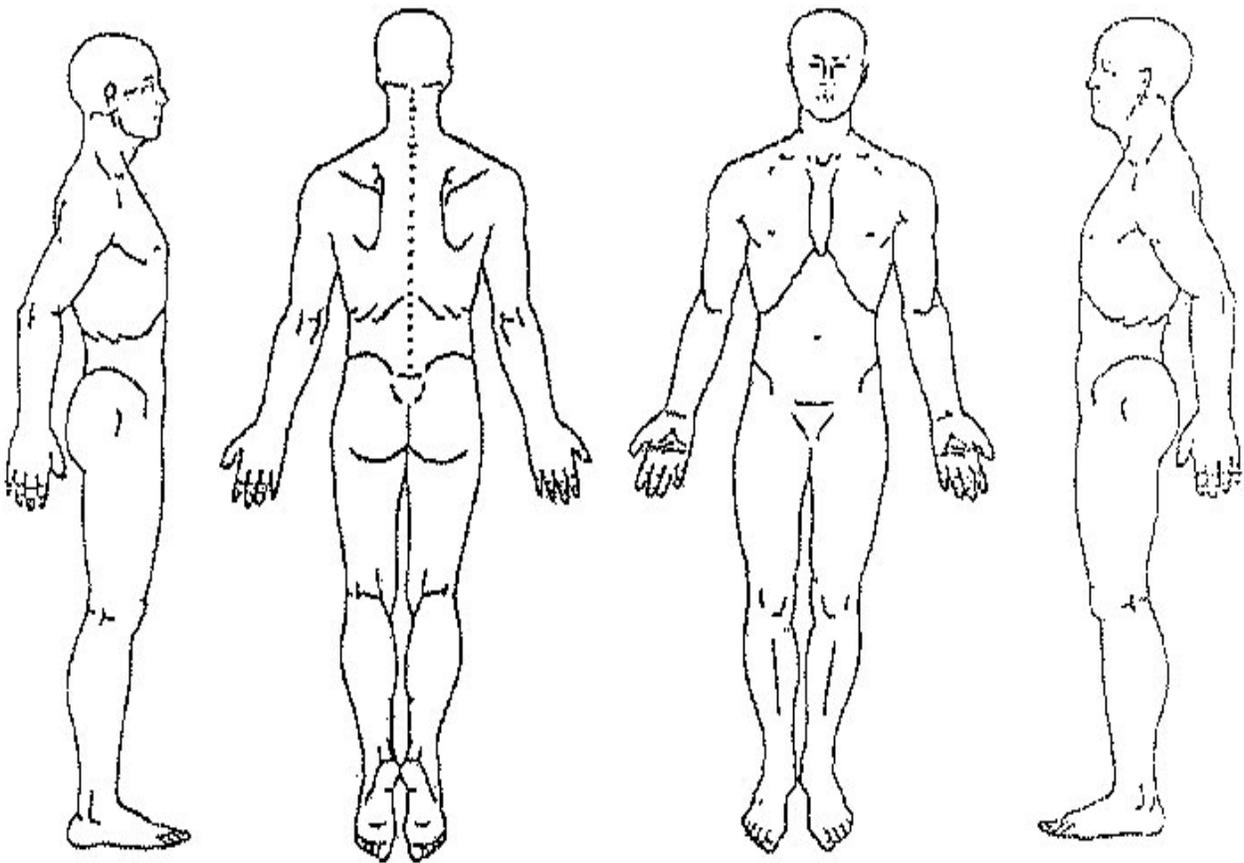
- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture
 Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal Implants
 Other _____ none of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder schizophrenia
 Psychiatric hospitalizations Homicidal ideations Other _____ None of the above

Patient Name: _____ Date: _____

Please mark areas of concern on the body's below. Number each area and then answer the Patient History Forms for each area marked.



Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 1: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
 Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 2: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
 Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 3: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
 Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 4: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
 Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 5: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
 Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e Headache, Neck Pain, etc.

Symptom 6: _____

- 1 On a scale of 0 – 10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- 2 What percentage of the time you are awake do you experience the above symptoms at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- 3 When did the symptom begin? _____
 Did the symptoms begin suddenly or gradually? (circle one)
 How did the symptom begin? _____

- 4 What makes the symptom worse? (Circle all that apply):
 Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- 5 What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

- 6 Describe the quality of the symptom (circle all that apply):
 Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe): _____

- 7 Does the symptom radiate to another part of your body? Circle one: Yes No
 If yes, where does the symptom radiate? _____

- 8 Is the symptom worse at certain times of the day or night? (Circle one)
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Patient Name: _____ Date: _____

HIPPA Consent Form

If I am a patient who is submitting to third party insurances for reimbursement, I know that I am giving this practice my consent to only disclose my protected health information to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review The Healing Centre's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing the consent.

I understand that The Healing Centre has the right to change their Privacy Practices and that I may obtain any revised notices at this practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand The Healing Centre cannot be restricted from providing information relating to the procedure codes billed to your insurance. I understand that The Healing Centre may restrict personal information if not directly related to the codes being billed.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already being used or disclosed.

Singnature: _____ Date: _____

If signed by a patient representative, state relationship to patient: _____

Patient Name: _____ **Date:** _____

Doctor-Patient Relationship in Chiropractic INFORMED CONSENT

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

Analysis

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows never transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Doctors of Chiropractic care experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care fore the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions, which do not respond to Chiropractic Care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

To The Patient

Please discuss any questions or problems with the Doctor before signing the statement of policy.

I have read, and understand the forgoing.

Signature

Date

Patient Name: _____ Date: _____

MISSED APPOINTMENT POLICY

PURPOSE

To make the patient aware that missed appointments have an impact on the physician's schedule as well as possible health risks for the patient. The Healing Centre is reserving time in our schedule for your health. To notify patients of a possible financial penalty for failure to cancel a scheduled appointment. We also may have patients in need of an appointment on a "wait" list.

POLICY

Our office will document in the electronic medical record when a patient "no shows" an appointment or cancels an appointment on short notice.

Failure to give 24-hour notice of cancellation of an appointment or no-showing an appointment can result in a charge of the visit on the patient's account. Patients signing this have acknowledged that they may be charged for missed appointments. This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts.

Medical care will not be withheld for a medical emergency. If no-showing occurs, please call right away, otherwise future appointments will be cancelled.

PROCEDURE

CHECK **ONE** BOX. **SIGN & DATE** BELOW.

I understand the Missed Appointment Policy. I have been informed that a charge will be applied to my account when I miss appointments without giving proper notice. I understand this charge cannot be billed to an insurance company. I agree personally and fully responsible for payment.

I have decided to not schedule in advance and I will call the day I would like to have an appointment. I understand there may not be time available the day I call.

Signature of patient or person acting on patient's behalf

Date