



Patient Information

Name: _____ Birth Date: ____/____/____ Age: _____ Gender: M F
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: () _____ Work Phone: () _____ Home Phone: () _____
Email: _____ Social Security #: ____/____/____ Marital Status: S M D W
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Spouse's Employer: _____
Do you have any children? Yes No If yes, what are their name and age: _____
How were you referred to this office? _____

Experience with Chiropractic

Have you seen a chiropractor before? Yes No If yes, how often? _____ day(s) per week; Other: _____
Reason for previous chiropractic visit(s): _____
Did your previous chiropractor take 'before' and 'after' x-rays? Yes No What was the diagnosis? _____
Did he or she recommend a specific course of treatment? Yes No
Did they recommend a Home Rehabilitation program? Yes No
If yes, what was it? _____
How did you respond to care? _____
Is there anything that you particularly 'liked' or 'disliked' about your previous chiropractic care? Yes No N/A
If yes, please explain: _____
Are you aware of any poor posture habits? Yes No Is there a history of spinal problems in your family? Yes No
If yes, please explain: _____

Lifestyle

Do you exercise? Yes No How often? _____ day(s) per week; Other: _____
What activities? Walking Running/Jogging Weight Training Cycling Yoga Pilates Swim Other _____
Do you smoke? Yes No How much?/ How often? _____
Do you drink alcohol? Yes No How much?/ How often? _____
Do you drink coffee? Yes No How much?/ How often? _____

In Case of Emergency

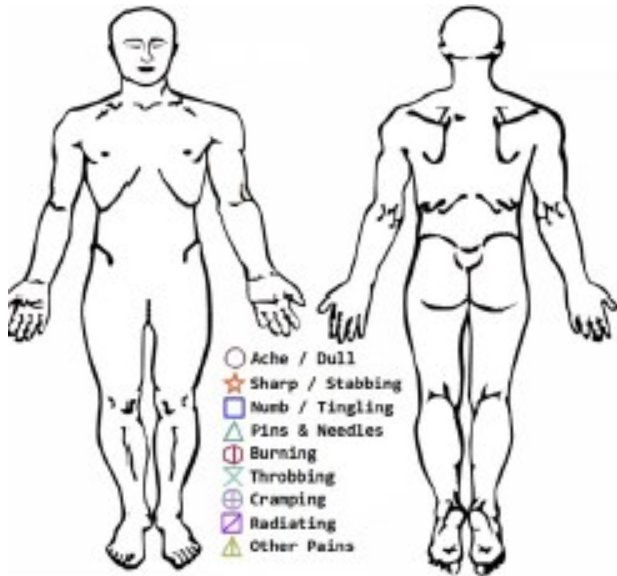
Name: _____ Relationship to Patient: _____
Phone: Cell() _____ Home() _____ Work () _____

Reason for your Visit

Purpose of appointment _____
Is this visit the result of: auto accident sports injury work injury trauma chronic problem other

Please fill out a separate diagram and question series for EACH area of complaint.

Mark where it hurts



Complaint #1

When did this condition begin? _____ What caused it? _____

Is the pain: constant frequent off and on random recurring other

What is the quality of the pain? aching burning deep dull pulling

sharp stabbing throbbing tingling other _____

Is it: improving staying the same worsening

Rank 0-10 (10 is worst): ____/10

What improves this condition? chiropractic cold packs exercise heat

massage nothing OTC meds Rest stretching other _____

What aggravates this condition? _____

Previous episodes of this condition? No Yes _____

What treatment have you received up to now? none acupuncture

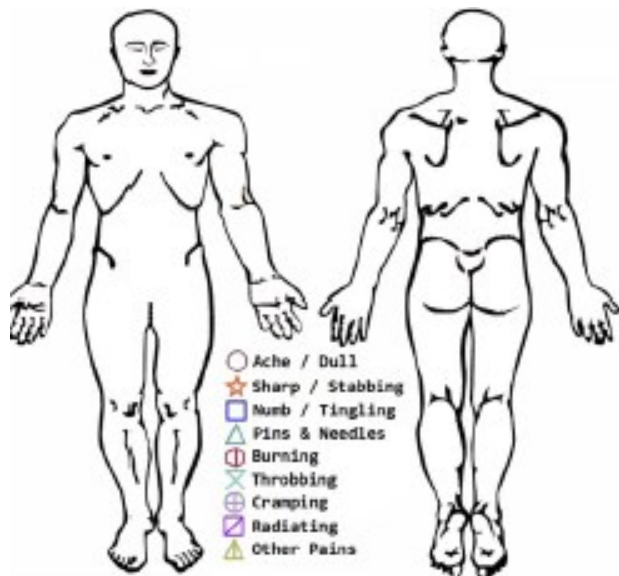
chiropractic homeopathy injections prescription meds physical

therapy psychotherapy other _____

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc...)

Yes No Unsure

Mark where it hurts



Complaint

When did this condition begin? _____ What caused it? _____

Is the pain: constant frequent off and on random recurring other

What is the quality of the pain? aching burning deep dull pulling

sharp stabbing throbbing tingling other _____

Is it: improving staying the same worsening

Rank 0-10 (10 is worst): ____/10

What improves this condition? chiropractic cold packs exercise heat

massage nothing OTC meds Rest stretching other _____

What aggravates this condition? _____

Previous episodes of this condition? No Yes _____

What treatment have you received up to now? none acupuncture

chiropractic homeopathy injections prescription meds physical

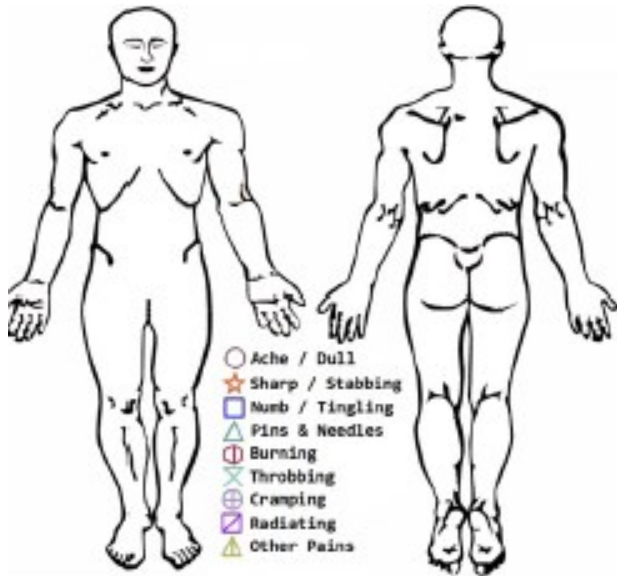
therapy psychotherapy other _____

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc...)

Yes No Unsure

Please fill out a separate diagram and question series for EACH area of complaint.

Mark where it hurts



Complaint #3

When did this condition begin? _____ What caused it? _____

Is the pain: constant frequent off and on random recurring other

What is the quality of the pain? aching burning deep dull pulling

sharp stabbing throbbing tingling other _____

Is it: improving staying the same worsening

Rank 0-10 (10 is worst): ____/10

What improves this condition? chiropractic cold packs exercise heat

massage nothing OTC meds Rest stretching other _____

What aggravates this condition? _____

Previous episodes of this condition? No Yes _____

What treatment have you received up to now? none acupuncture

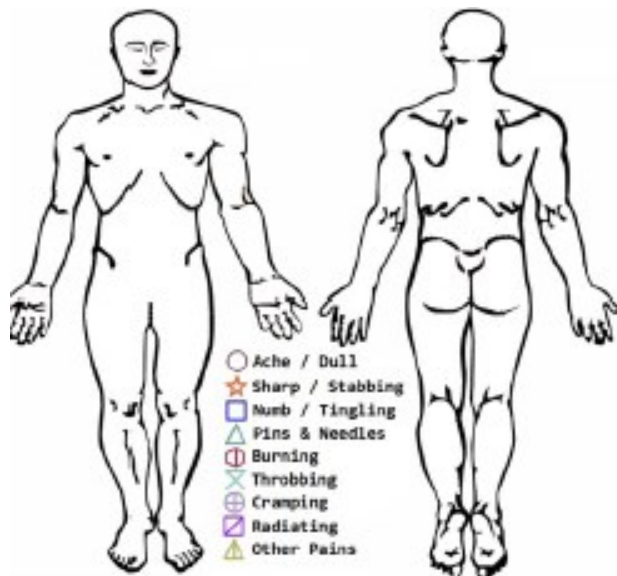
chiropractic homeopathy injections prescription meds physical

therapy psychotherapy other _____

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc...)

Yes No Unsure

Mark where it hurts



Complaint #4

When did this condition begin? _____ What caused it? _____

Is the pain: constant frequent off and on random recurring other

What is the quality of the pain? aching burning deep dull pulling

sharp stabbing throbbing tingling other _____

Is it: improving staying the same worsening

Rank 0-10 (10 is worst): ____/10

What improves this condition? chiropractic cold packs exercise heat

massage nothing OTC meds Rest stretching other _____

What aggravates this condition? _____

Previous episodes of this condition? No Yes _____

What treatment have you received up to now? none acupuncture

chiropractic homeopathy injections prescription meds physical

therapy psychotherapy other _____

Were any diagnostic tests performed to assess this condition (MRI's, x-rays, etc...)

Yes No Unsure

Health Conditions - Review of Systems

Your spine is the foundation of health and strength for your body. Shifts in vertebrae can cause the body to compensate and render the entire structure weak. Research shows that abnormal posture leads to chronic pain, disease, and possibly shorten life span.

(Postural and Degenerative Kyphosis: Freeman JT. Poster in the Aging and Aged Body. JAMA 1957, Oct 19:843-846.)

(Please circle the appropriate number "0-3" on all questions below. 0 - never 3 - frequent)

CERVICAL SPINE (NECK)

- | | | |
|---|----------------------------------|----------------------------------|
| Neck Pain0 1 2 3 | Headaches0 1 2 3 | Sinusitis0 1 2 3 |
| Pain in shoulders/arms/hands.....0 1 2 3 | Dizziness0 1 2 3 | Allergies/Hay Fever0 1 2 3 |
| Numbness/tingling in arms/hands.. 0 1 2 3 | Visual Disturbances..... 0 1 2 3 | Recurrent Colds/Flu.....0 1 2 3 |
| Hearing Disturbances..... 0 1 2 3 | Coldness in Hands..... ..0 1 2 3 | Low Energy/Fatigue..... 0 1 2 3 |
| Weakness in Grip..... 0 1 2 3 | Thyroid Conditions..... 0 1 2 3 | TMJ/Pain/Clicking..... 0 1 2 3 |

THORACIC SPINE (UPPER BACK)

- | | | |
|-----------------------------------|---------------------------------------|--|
| Heart Palpitations..... 0 1 2 3 | Recurrent Lung Infections.....0 1 2 3 | Unstable blood sugar0 1 2 3 |
| Heart Murmurs0 1 2 3 | Asthma/Wheezing0 1 2 3 | Gas following meal0 1 2 3 |
| Tachycardia.....0 1 2 3 | Shortness of Breath.....0 1 2 3 | Excessive burp/bloating.....0 1 2 3 |
| Heart Attacks/Angina..... 0 1 2 3 | Gas following a Meal..... 0 1 2 3 | Difficulty digesting fruits or
Vegetables.....0 1 2 3 |

THORACIC SPINE (MID BACK)

- | | | |
|---|--|---------------------------|
| Mid Back Pain..... 0 1 2 3 | Nausea..... 0 1 2 3 | Diabetes0 1 2 3 |
| Pain in ribs/Chest0 1 2 3 | Ulcers/Gastritis0 1 2 3 | Hypoglycemia0 1 2 3 |
| Indigestion/Heartburn.....0 1 2 3 | Reflux.....0 1 2 3 | Hyperglycemia.....0 1 2 3 |
| Tired/Irritable after eating..... 0 1 2 3 | Tired/Irritable for missed meals.....0 1 2 3 | |

LUMBAR SPINE (LOW BACK)

- | | | |
|--|--|-----------------------------------|
| Lower back pain..... 0 1 2 3 | Weak/Injuries in hip/knee/ankle....0 1 2 3 | Coldness in legs/feet.....0 1 2 3 |
| Pain in hips/legs/feet0 1 2 3 | Recurrent Bladder Infections.... ..0 1 2 3 | Sexual dysfunction.....0 1 2 3 |
| Numbness/tingling in legs/feet.....0 1 2 3 | Muscle Cramps in Legs/Feet.....0 1 2 3 | Constipation/Diarrhea.....0 1 2 3 |
| Frequent/difficulty urinating..... 0 1 2 3 | Menstrual Irregularities/Cramping. 0 1 2 3 | |

Family Health History

Have any of your family members ever been diagnosed with the following (please indicate "Y" for You, "O" for Other than you, or both if applicable):

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Eczema |

OTHER:

Please list any conditions not mentioned:

Please list any medications and supplements that you take (include name, dose, for what condition and for how long you've taken it):

Please list any surgeries (include type of surgery and date it was performed):

Informed Consent for Diagnostic X-Rays and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy, including but not limited to ice, heat, massage, laser, spinal decompression, MyACT and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of Health First Spine & Wellness or any doctor, who now or in the future works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, dislocations, sprains, soreness etc.. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing.

I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest. This consent will cover entire course of treatment for my present condition and for all future conditions.

Patient Signature: _____ Date: ____/____/____

Insurance Authorization

I authorize payment of insurance benefits directly to Health First Spine & Wellness, I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Health First to communicate with my medical physician(s) about my condition and treatment. I understand and agree that **ultimately I am responsible for all costs** of chiropractic care, regardless of insurance coverage. I also understand and agree 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 the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

Although our office do a courtesy insurance check, **it is your responsibility to confirm and know your benefits.**

I have read and understand how my PHI will be used and I agree to these policies and procedures.

I intend this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment in this office.

Patient Signature: _____ Date: ____/____/____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his 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 cycle: ____/____/____ Patient Signature: _____ Date: ____/____/____

Consent to Treatment of a Minor

I hereby authorize the doctors of HealthFirst Spine & Wellness, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent or Legal Guardian _____ Relationship _____

Date: ____/____/____

Patient Health Information Consent Form

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 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 not obligated to agree to those restrictions.
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 effect 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. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer 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.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.

Signature _____ Date ____/____/____