CHIROPRACTIC

Bringing out the best in you

Practice Member _____

Doctor _____

Date _____ Case # _____

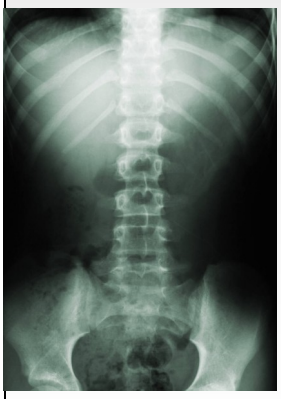
New Patient

Welcome To Our Office

Name _____ Preferred Name _____
Address _____
City/State/Zip _____
Phone #s (home) _____ (cell) _____ (work) _____
Is it okay to contact you at work? ❑ No ❑ Yes
E-mail address _____ Web site _____
Birthday _____ Age _____
Occupation _____ Employer _____
Marital Status ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed
Spouse's name _____ Phone #(s) _____
Children's names and ages _____
_____
Emergency Contact: Name _____
Relationship _____ Phone #(s) _____
Favorite hobbies or interests _____

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future.** In order to give you the best possible Chiropractic care, we will need to discover any ***'stresses'*** that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.



What brings you here?

Have you ever had chiropractic care? ❒ No ❒ Yes
Were you pleased with your care? ❒ No ❒ Yes
How did you find out about our office? _____
Is this appointment related to: ❒ wellness ❒ work ❒ sports
❒ auto ❒ personal injury ❒ other

_____

Please describe your current problem, including the effect it has had on your life:

_____
_____
_____
_____

How often are the complaints present?

❒ Constant (76-100%) ❒ Frequent (51-75%)
❒ Occasional (26-50%) ❒ Intermittent (25% or less)

When is the pain or symptoms worse:

❒ When you wake up ❒ During the day ❒ After work
❒ In the evening ❒ After eating ❒ While sleeping

How bad is your pain or ache? Please circle a number (0 = no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

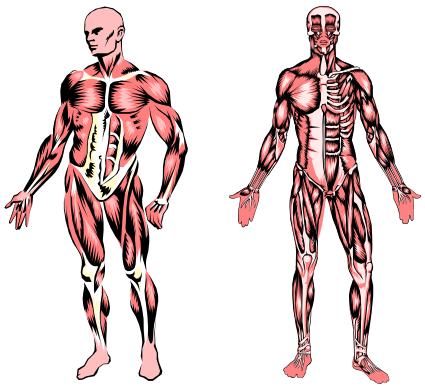
Since your problem began is the pain: ❒ increasing ❒ decreasing ❒ not changing

When did your problem begin: _____ (specific date if possible)

Please draw on the diagram(s) below to indicate where you feel your symptoms:

Do you sleep on your:

❒ Back ❒ Stomach ❒ Left side ❒ Right side



Physical activity at work:

❒ Sitting more than 50% ❒ Light manual labor
❒ Heavy manual labor

General physical activity

❒ No regular exercise program
❒ Light exercise program
❒ Strenuous exercise program

How would you rate your stress level?

❒ No stress ❒ Minimal stress ❒ Moderate stress ❒ Greatly stressed

Do you currently smoke? Yes No. If YES, please indicate how many packs/day___
Number of years:_____

Who else have you seen for this condition?

Are you receiving care from other health professionals? ❒ No ❒ Yes

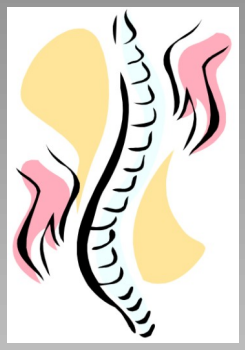
If yes, please name them and their specialty _____
_____

Please list any drugs or medications you are taking _____
_____
_____

Please list any vitamins/herbs/homeopathics/other you are taking _____
_____
_____

Are you pregnant? ❒ No ❒ Yes If yes, what month? _____

Health History



Do you have, or have you had , any of the following: (please check all that apply)

❒ pneumonia	❒ mumps	❒ influenza	❒ pneumatic fever	❒ smallpox
❒ pleurisy	❒ polio	❒ chickenpox	❒ thyroid disease	❒ diabetes
❒ epilepsy	❒ cancer	❒ depression	❒ whooping cough	❒ anemia
❒ eczema	❒ measels	❒ arthritis	❒ heart disease	❒ rashes

If you have ever been diagnosed with another disease or condition, please describe: ___
_____

Do you use ❒ coffee ❒ tea ❒ artificial sweeteners ❒ sugar
❒ alcohol ❒ cigarettes ❒ recreational drugs

Have you ever suffered from (*please check ☑ all that apply*)

❒ neck pain	❒ stuffy nose	❒ discolored urine
❒ low back pain	❒ allergies	❒ gas/bloating after meals
❒ headache	❒ fainting	❒ heartburn
❒ migraines	❒ weight loss	❒ colitis
❒ arm pain/tingling	❒ poor appetite	❒ irritable bowel
❒ shoulder pain	❒ excessive appetite	❒ black or bloody stools
❒ hand pain/tingling	❒ nervousness	❒ constipation
❒ leg pain/tingling	❒ confusion	❒ hemorrhoids
❒ jaw pain	❒ depression	❒ liver problems
❒ chest pain	❒ dental problems	❒ stroke
❒ lung problems	❒ excessive thirst	❒ paralysis
❒ heart problems	❒ frequent naseau	❒ tingling
❒ abnormal blood pressure	❒ vomiting	❒ numbness
❒ irregular heartbeat	❒ prostate problem	❒ fatigue
❒ ankle swelling	❒ breast pain / lump	❒ dizziness
❒ cold extremeties	❒ cramps	❒ loss of sleep
❒ blurred vision	❒ painful urination	❒ difficulty hearing
❒ vision problems	❒ bladder trouble	❒ ear pain
❒ difficulty breathing	❒ excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ☑ all that apply*)

❒ falls/accidents	❒ head injuried	❒ fights
❒ sports injuries	❒ broken bones	❒ dislocations
❒ spinal tap	❒ surgery	❒ traction
❒ use(d) cane or walker	❒ extensive dental work	❒ dental appliances
❒ knocked unconscious		

If yes to any of the above, please describe briefly_____
_____
_____
_____
_____

How would you rate your health:

Yuk I've never felt worse — Wow I feel great!

1 2 3 4 5 6 7 8 9 10

If you rated your health as anything less than an 8, how committed are you to improving your health:
____ (indicate a number 1-5 with 1 being 0% committed & 5 being 100%)

Do you want to live to be a healthy 85 years old? Yes No

What are your goals and/or expectations with Chiropractic care: _____
_____
_____

Other Health Concerns:_____
_____

What do you know about chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❒ No ❒ Yes

If yes, please describe _____

_____

_____

Do any friends or relatives use chiropractors? ❒ No ❒ Yes

If yes, do they use chiropractic for ❒ health maintenance/optimization

❒ health problems ❒ both

Are you seeking chiropractic for ❒ health maintenance/optimization

❒ health problems ❒ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

❒ No ❒ Yes If yes, please tell us_____

_____

_____

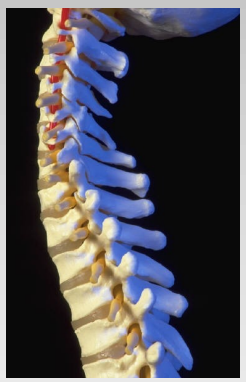
_____

Notes _____

_____

_____

_____



Financial Responsibility

Who is responsible for payment? _____

(We will not bill your insurance. The following information will be used to complete your receipts for reimbursement only.)

Insurance co. _____ Group # _____

Policy # _____ Phone _____

Address _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge. I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office.

_____ _____

(Patient Signature or Parent/Guardian) (Date)

VILLAGE CHIROPRACTIC

INSURANCE POLICY

It is our office policy that all services rendered in this office are charged directly to you, the patient, and not to the insurance company.

A receipt for services will be provided, if requested, to submit to your insurance company for direct reimbursement to you.

All payments are expected at the time of service.

This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement for your records.

Please keep one copy of the insurance statement for your own records.

If you have any questions, please do not hesitate to ask.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. ***I also understand that a 10% per month interest fee may be added to my outstanding balances. I am also responsible for ANY fees incurred by Village Chiropractic in the collection of overdue accounts.***

Name _____

Patient signature _____ Date_____

Village Chiropractic . 906-225-8000 . 1012 N. Third St.,

Terms of Acceptance

When a patient seeks chiropractic 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 it maximum health potential.*

We do not offer to diagnose or treat any disease of 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 a health care provider who specializes in that area.

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 statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature_____ Date _____

Consent to Evaluate and Adjust a Minor

I _____ *being the parent or legal guardian of*

_____ *have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.*

Signature of Parent/Guardian_____ Date _____

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the 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 _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you tot hem for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or my mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Patient Printed Name Authorized Provider Representative

_____ _____

Patient Signature Date

_____

Date