Healthline Chiropractic Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________________________

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. **First Name**_________________________ **Middle**_____________________

Last Name _____________________________________ **Nick name**_____________________________________

Address ____

City____ **State**____________ **Zip Code** _____________________

Date of Birth_________ **Age**_______ ❑ Male ❑ Female

Mobile Phone ______________________________ **Cell Phone Carrier**_________________________________

Home Phone _______________________________ **Email** ____

By providing my email address, I authorize my doctor to send a link so I may access my medical records.

Marital Status ❑ Single ❑ Married ❑ Other **Spouse's Name**_______________________________________

Emergency Contact _______________________________ **Phone #**_____________________________________

Who or how were you referred you to our office?

❑ Family ❑ Friend ❑ Physician ❑ Employer ❑ Yellow pages ❑ Drive-by
❑ Website ❑ LA Fitness ❑ Massage referral

If family, friend, physician or employer please specify: ____

Employment ❑ Employed ❑ FT Student ❑ PT Student ❑ Other **Occupation**_______________________

Primary Physician___________________________ **Address**____

Phone #____________________________________ **Email** ____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications: Including frequency and dosage, if known. ❑ **No current medications**

Start Date	Start Date
1) ____	**5)** ____
2) ____	**6)** ____
3) ____	**7)** ____
4) ____	**8)** ____

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) ____ 2) ____

Major Complaints (check all that apply):

Grade your pain for each complaint from 0-10 with 10 being the highest level of pain.

❑___Neck pain ❑___Headaches ❑___Upper back pain ❑___Mid back pain ❑___Low back pain

❑___Arm pain ❑___Leg pain ❑___Hip pain ❑___Stiffness ❑___Numbness/tingling

❑Other: ____

How did these symptoms develop? (What caused it?) Please be as specific as possible: ______________________

____

Did the symptoms start… ❑ Gradually ❑ Suddenly How many: Weeks? ___________ Months? _____________

How intense is your pain? ❑ Minimal ❑ Slight ❑ Moderate ❑ Severe

Does the pain radiate to another area of the body? ❑ Yes ❑ No **If yes, where?** ________________________

Who have you seen for your symptoms? ____

Have you had an X-ray, CT scan, or MRI of your <u>low back</u> spine? ❑ Yes ❑ No **Date** ___________________

List all surgical operations and years: ____

____

Have you had previous chiropractic care? ❑ Yes ❑ No

If you have, name of doctor and date of care: ____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type **I** ❑ Type **II**

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____

Height _________ Feet ________ Inches **Weight**______________ **BP**________/________

Signature of Doctor ____________________________________ Date ___________________________________

Personal Health History

Have you had trouble with any of the following:

Cardiovascular ❑ NO

	Present	Past
Poor circulation	❑	❑
High blood pressure	❑	❑
Aortic aneurysm	❑	❑
Heart disease	❑	❑
Vascular disease	❑	❑
Heart attack	❑	❑
Chest pain	❑	❑
High cholesterol	❑	❑
Pace maker	❑	❑
Jaw Pain	❑	❑
Irregular heartbeat	❑	❑
Swelling of legs	❑	❑

Genitourinary ❑ NO

	Present	Past
Kidney disease	❑	❑
Lower side pain	❑	❑
Burning urination	❑	❑
Frequent urination	❑	❑
Blood in urine	❑	❑
Kidney stone	❑	❑

Hematological/Lymphatic ❑ NO

	Present	Past
Hepatitis	❑	❑
Blood clots	❑	❑
Cancer	❑	❑
Easy bruising	❑	❑
Easy bleeding	❑	❑
Fevers/chills/sweats	❑	❑

Respiratory ❑ NO

	Present	Past
Asthma	❑	❑
Tuberculosis	❑	❑
Shortness of breath	❑	❑
Emphysema	❑	❑
Cold/flu	❑	❑
Cough/wheezing	❑	❑

Ear Nose & Throat ❑ NO

	Present	Past
Dizziness	❑	❑
Hearing loss	❑	❑
Sinus infection	❑	❑
Nosebleed	❑	❑
Sore throat	❑	❑
Difficulty swallowing	❑	

Eyes ❑ NO

	Present	Past
Glaucoma	❑	❑
Double vision	❑	❑
Blurred vision	❑	❑

Integumentary ❑ NO

	Present	Past
Skin lesions	❑	❑
Skin ulcers	❑	❑
Skin disease	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Rashes	❑	❑

Allergic/Immunologic ❑ NO

	Present	Past
Hives	❑	❑
Immune disorder	❑	❑
HIV/AIDS	❑	❑
Allergy shots	❑	❑
Cortisone use	❑	❑

Gastrointestinal ❑ NO

	Present	Past
Gall bladder problems	❑	❑
Bowel problems	❑	❑
Constipation	❑	❑
Liver problems	❑	❑
Ulcers	❑	❑
Diarrhea	❑	❑
Nausea/vomiting	❑	❑
Bloody stool	❑	❑
Poor appetite	❑	❑

Musculoskeletal ❑ NO

	Present	Past
Gout	❑	❑
Arthritis	❑	❑
Joint stiffness	❑	❑
Muscle weakness	❑	❑
Osteoporosis	❑	❑
Broken bones	❑	❑
Joints replaced	❑	❑

Endocrine ❑ NO

	Present	Past
Thyroid disease	❑	❑
Diabetes	❑	❑
Hair loss	❑	❑
Menopausal	❑	❑
Menstrual problems	❑	❑

Constitutional ❑ NO

	Present	Past
Weight loss/ gain	❑	❑
Energy level problems	❑	❑
Difficulty sleeping	❑	❑

Neurological ❑ NO

	Present	Past
Stroke	❑	❑
Seizures	❑	❑
Head injuries	❑	❑
Brain aneurysm	❑	❑
Numbness	❑	❑
Severe Headaches	❑	❑
Pinched nerve	❑	❑
Parkinson’s Disease	❑	❑
Carpal tunnel	❑	❑
Spinning/ balance	❑	❑

Psychiatric ❑ NO

	Present	Past
Depression	❑	❑
Anxiety	❑	❑
Stress	❑	❑

Other ❑ NO

	Present	Past
Cancer	❑	❑
Spinal Surgery	❑	❑
Spinal Bone Fracture	❑	❑
Scoliosis	❑	❑

Family Health History

This form is to assist the doctors by providing past health history information for their review.

Date: ___________________________ **Patient Name:** ____

Condition	Spouse	Son	Daughter	Mother	Father
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
MENSRTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SINUS TROUBLE					
TMJ					

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box. If an activity does not cause pain or if pain does not affect an activity, leave box blank.

- **[1]** This activity **causes slight pain**, but I can do it.
- **[2]** This activity **causes mild pain**, but I can do it.
- **[3]** This activity **causes me moderate pain** & I can do it **<10 minutes**.
- **[4]** This activity **causes me moderate pain** & I can do it **<5 minutes**.
- **[5]** This activity **causes me severe pain** & I can do it **<10 minutes**.
- **[6]** This activity **causes me severe pain** & I can do it for **< 5 minutes**.
- **[7]** I **cannot perform** this activity due to pain and disability.

Self Care and Personal Hygiene:

	Bathing/ Showering		Washing Dishes
	Brushing teeth		Going to bathroom
	Putting on shoes		Washing face
	Eating		Putting on shirt
	Doing Laundry		Cooking
	Grooming hair		Taking out the trash
	Making the bed		Vacuuming
	Putting on pants		Sweeping

Physical Activities:

	Standing		Sitting
	Reclining		Walking
	Squatting		Kneeling
	Stooping		Bending forward
	Bending backward		Reaching overhead
	Reaching forward		Looking over your shoulder
	Throwing		Bending to the side

Functional Activities:

	Carrying small objects		Carrying gallon of milk
	Carrying large objects		Carrying bag/purse
	Mowing lawn		Cleaning windows
	Lifting weights off table		Exercising upper body
	Exercising lower body		Lifting object off floor
	Shoveling snow		Cleaning curtains
	Climbing stairs		Raking leaves
	Weeding		Pushing or pulling

Social and Recreational Activities:

	Bowling		Biking
	Jogging		Walking
	Hunting/ fishing		Knitting/ crocheting
	Swimming		Competitive sports
	Playing cards		Golfing
	Gardening		Dancing
	Yoga		Sewing
	Weeding		Other: _____________

Difficulties with Traveling:

	Getting into/out of car		Driving in car for short periods of time
	Driving for long periods of time		Riding as passenger for short periods of time
	Riding as passenger for long periods of time		Riding in an airplane
	Riding on a bus		Exercising upper body
	Exercising lower body		

Other activities:

Use this scale for the following activities:

- **[1]** This activity is **slightly** affected by my condition.
- **[2]** This activity is **mildly** affected by my condition.
- **[3]** This activity is **moderately** affected by my condition.
- **[4]** This activity is **severely** affected by my condition.
- **[5]** I **cannot perform** this activity due to my condition.

	Concentrating		Reading
	Studying		Writing
	Using computer		Sleeping
	Looking down at cell phone		Coughing
	Sneezing		Sexual relations

Patient Name: ___________________________ **DOB:** ___________ **Doctor Signature:** ___________________________ **Date:** ______________

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all other forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

Print Name: ________________________________

Signature: ________________________________ **Date:** ________________________________

If patient is a minor/child, parent or guardian must sign below.

Signature of parent or guardian: ________________________________ **Date:** ________________________________

Relationship to minor/child: ________________________________

X-RAY AUTHORIZATION

As your Healthcare Provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you a copy of your x-rays in our files. The fee for copying your x-rays is $5.00 per film. This fee must be paid in advance.

Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Healthline Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found we will bring them to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: ________________________________ **Age:** ________________________________

Signature: ________________________________ **Date:** ________________________________

Female patients only: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken at Healthline Chiropractic.

Signature: ________________________________ **Date:** ________________________________

<u>FINANCIAL POLICY</u>

Thank you for choosing us as your health care provider. We are committed to treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

- All patients must complete our information form and provide a copy of their driver's license and insurance card(s).
- Full payment is due at time of service unless arranged prior to treatment with the accounts manager.
- We accept cash, checks, Discover, Visa, American Express, or MasterCard.
- We offer an extended payment plan with prior credit approval.

Regarding insurance:
We may accept assignment of your insurance benefits. However, you will be responsible for any deductibles or copays that your insurance requires of you. Your insurance policy is a contract between you and your insurance provider. We are not a party to this contract. Our practice is committed to providing the best for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Regarding insurance where we are a participating provider:
All copays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to paragraph above.

Cash patients will solely be accountable for their account balance. Payment is expected at time of service unless charges have been discussed with the account manager.

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non emergency treatment will be denied unless charges have been pre-authorized by the guardian of said minor.

The policy here at HEALTHLINE CHIROPRACTIC CLINIC is that all accounts are due within 30 days of service if pre-approved for payment plan. In the event you fail to follow these policies, please be aware that 15% monthly service charge may be added to your bill.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy for HEALTHLINE CHIROPRACTIC CLINIC. I understand and agree to the Financial Policy.

Name: ______________________________________ **Date: ___________________________**

Signature: ___________________________________

HIPPA

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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. We at Healthline Chiropractic Clinic will never release any of the information outside of this office except to your insurance company and only when authorized by your signature.

There are several circumstances in which we may have to use 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 to them for diagnosis, assessment, or treatment of your 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.

APPOINTMENT REMINDERS AND HEALTHCARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

SPECIAL AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records for the purpose of marketing services to you. We are specifically requesting authorization to thank patients for referrals, by sending a thank you note. From time to time, we run a patient recall program to remind patients the value of chiropractic care. We post pictures of our patients in our office and acknowledge their birthdays with a call or card. Please feel free to ask us at any time for a full copy of privacy notices.

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 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 to us.

RIGHT TO REVOKE AUTHORIZATION

You may revoke 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 a right to your health information if they decide to contest any of your claims.

RIGHT TO REFUSE AUTHORIZATION

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I have read your consent policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

This authorization will expire seven years after the date on which you sign this document.

Print Name: ____ **Date:** _________________________

Signature: ____

Personal Representative Printed: __________________________________ **Relationship:** __________________________

Personal Representative Signature: ________________________________

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following pain regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not that practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxations(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indication of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, ect., is essential to maximum healing and optimal health through chiropractic.
G. We are dedicated to maintaining a supportive, open environment. We invite you to speak openly to the doctor on any matter related to your care at this facility.

By my signature below, I have read and fully understand the above statements.

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

Signature: ________________________________ **Date: ______________________________**