Welcome to Healthline Family Chiropractic & Massage!

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Today's Date: _____

Last Name: _____ Middle: ___ First: _____ Date of Birth: _____ Age: _____ M / F

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

Cell / Home Phone: _____ Cell Phone Carrier: _____ Email: _____

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

Preferred Contact Method: ❑ Cell phone ❑ Home Phone ❑ Email

Emergency contact: _____ Phone #: _____

Who or how were you referred to our office? ❑ Online/Website ❑ Family Member ❑ Close to home/work
❑ Physician/Health Care Provider ❑ Friend *Tell us their name so we can thank them:* _____

Primary physician: _____ Group name & City_____

Phone #: _____ Fax #: _____ *(important for sharing medical records)*

Major Complaints (check all that apply and circle left/right): ❑ Neck pain L / R ❑ Arm pain L / R ❑ Headaches

❑ Upper back pain L / R ❑ Mid back pain L / R ❑ Low back pain L / R ❑ Leg pain L / R ❑ Hip pain L / R

❑ Numbness/Tingling ❑ Other: _____

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

_____

Did the symptoms start... ❑ Gradually ❑ Suddenly

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

Does the pain radiate, shoot, or travel to any other part of the body? ❑ Yes ❑ No

If yes, where? _____

Is this due to a(n): ❑ Auto Accident ❑ Work Injury ❑ Personal Injury / Lawsuit ❑ N/A

My symptoms are present: ❑ 25% of the day ❑ 50% of the day ❑ 75% of the day ❑ 100% of the day

Have you had similar problems in the past? ❑ Yes ❑ No If so, when? _____

Were you treated for this problem in the past? ❑ Yes ❑ No If so, when? _____

Have you had any other recent treatment for this condition? ❑ Yes ❑ No

What do your symptoms feel like?

❑ Sharp ❑ Sore ❑Spasms ❑ Stabbing ❑ Tingling ❑ Aching ❑ Stiff ❑ Cramping

❑ Dull ❑ Tight ❑ Shooting ❑ Throbbing ❑ Numbness ❑ Burning

Patient Signature: _____

What aggravates your symptoms?

❑ Sitting ❑ Driving ❑ Lifting ❑ Standing ❑ Bending

❑ Laying Down ❑ Stair Climbing ❑ Twisting ❑ Walking

❑ Inactivity/Sleeping ❑ Reaching ❑ Running ❑ Desk Work

❑ Getting up from a chair ❑ Sneezing/Coughing ❑Stress

❑ Housework ❑ Exercise ❑ Personal Hygiene

❑ Other: _____

What relieves your symptoms?

❑ Rest ❑ Heat ❑ Ice ❑ Sitting ❑ Stretching

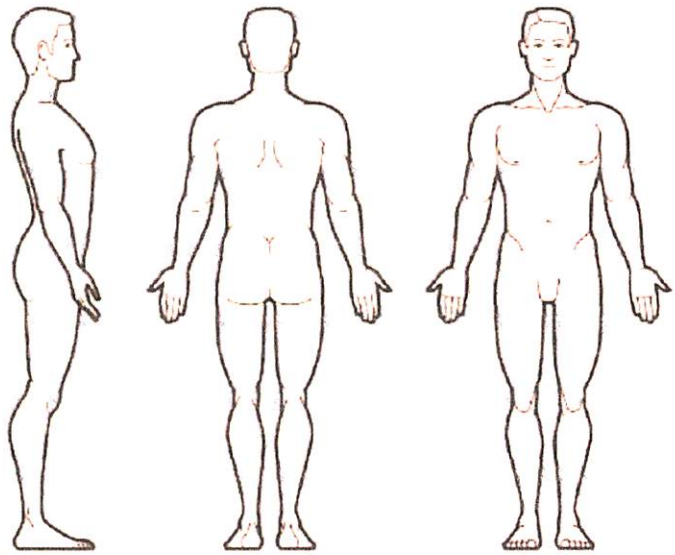
❑ Laying down ❑ Standing ❑ Exercises

❑ Supplements ❑ Chiropractic ❑ Physical Therapy

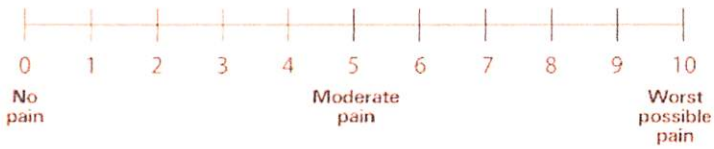
❑ Massage ❑ Medication ❑ Nothing

❑ Other: _____

Please circle or mark on the body diagram to indicate where you are having pain and/or symptoms:



Please rate your pain:



Symptoms are the most severe:

❑ In the Morning ❑ In the Afternoon ❑ In the Evening

❑ During activities ❑ After Activities ❑ At Night/Sleeping

❑ Symptoms are constant ❑ Other:

This condition is interfering with my:

❑ Personal Hygiene ❑ Housework

❑ Daily Routine ❑ Social Activities

❑ Work Activities ❑ Mobility

Initials: _____ I give permission for Healthline Chiropractic to share my medical records with my other health care providers.

Initials: _____ To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect or incomplete information can have a negative effect on treatment outcomes. It is my responsibility to inform Healthline Chiropractic of any changes in my health status.

Medical History

List all surgical operations and years: _____

_____

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

Females Only: Are you currently pregnant? ❑ Yes ❑ No Have you ever given birth? ❑ Yes ❑ No

# of children: _____ Type of Birth: ❑ Vaginal ❑ C-Section

Painful or Abnormal Menstrual Cycle? ❑ Yes ❑ No

Patient Initials: _____ Date: _____

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

Height: _____ft _____in Weight: _____lbs Typical Blood Pressure: _____

Current medications: Including frequency, and dosage, if known. ❑ No current medications ❑ No changes in 1yr

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Family Medical History

Please indicate who in your family has had arthritis, cancer, diabetes, high blood pressure, stroke, heart problems, genetic disorders, mental health issues, or any other serious health issues below:

Father: _____ Grandfather: _____ Sibling: _____

Mother: _____ Grandmother: _____ Children: _____

Review of Symptoms

Please mark whether or not you have problems with any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Weight Loss	❑	❑	Asthma/Chronic Cough	❑	❑	Fibromyalgia
❑	❑	Fatigue	❑	❑	Emphysema/COPD	❑	❑	Joint Pain or Stiffness
❑	❑	Fever or Chills	❑	❑	Difficulty Swallowing	❑	❑	Muscle Pain or Soreness
❑	❑	Weakness	❑	❑	Nausea or Heartburn	❑	❑	Redness or Swelling of Joints
❑	❑	Vision Loss/Changes	❑	❑	Change in Appetite			
❑	❑	Hearing Loss/Changes	❑	❑	Change in Bowel Function	❑	❑	Headaches/Migraines
❑	❑	Sinus Problems				❑	❑	Jaw Pain/TM Problems
❑	❑	Sore Throat	❑	❑	Change in Bladder Function	❑	❑	Arthritis
❑	❑	Mouth Sores				❑	❑	Bone Fractures or Dislocations
❑	❑	Chest Pain or Discomfort	❑	❑	Constipation or Diarrhea			
❑	❑	Shortness of Breath	❑	❑	Change in Urinary Frequency	❑	❑	Osteoporosis
❑	❑	Heart Palpations				❑	❑	Skin Rashes, Itching or Dry Skin
❑	❑	Swelling of Limbs	❑	❑	Burning or Pain with Urination			
❑	❑	Stroke/High Blood Pressure	❑	❑	Incontinence	❑	❑	Hair or Nail Changes
			❑	❑	Blood in Urine or Stool	❑	❑	Dizziness
❑	❑	Anemia	❑	❑	Prostate Problems	❑	❑	Fainting
❑	❑	Bleeding Disorders	❑	❑	Thyroid Problems	❑	❑	Epilepsy/Seizures
❑	❑	Swollen Glands/Lymph Nodes	❑	❑	Heat or Cold Intolerance	❑	❑	Anxiety/Depression
			❑	❑	Night Sweats	❑	❑	Memory Loss
❑	❑	Auto Immune Disease	❑	❑	Frequent Urination or Thirst	❑	❑	Difficulty Sleeping
❑	❑	Cancer				❑	❑	Allergies

Patient Initials: _____ 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:** _____

FINANCIAL POLICY

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:** _____