

# Yearly Update of Information

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 #: \_\_\_\_\_

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? \_\_\_\_\_

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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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
<input type="checkbox"/>	<input type="checkbox"/> Weight Loss	<input type="checkbox"/>	<input type="checkbox"/> Asthma/Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain or Stiffness
<input type="checkbox"/>	<input type="checkbox"/> Fever or Chills	<input type="checkbox"/>	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/> Muscle Pain or Soreness
<input type="checkbox"/>	<input type="checkbox"/> Weakness	<input type="checkbox"/>	<input type="checkbox"/> Nausea or Heartburn	<input type="checkbox"/>	<input type="checkbox"/> Redness or Swelling of Joints
<input type="checkbox"/>	<input type="checkbox"/> Vision Loss/Changes	<input type="checkbox"/>	<input type="checkbox"/> Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/>	<input type="checkbox"/> Hearing Loss/Changes	<input type="checkbox"/>	<input type="checkbox"/> Change in Bowel Function	<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain/TM Problems
<input type="checkbox"/>	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/> Change in Bladder Function	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Sore Throat	<input type="checkbox"/>	<input type="checkbox"/> Constipation or Diarrhea	<input type="checkbox"/>	<input type="checkbox"/> Bone Fractures or Dislocations
<input type="checkbox"/>	<input type="checkbox"/> Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/> Change in Urinary Frequency	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/> Chest Pain or Discomfort	<input type="checkbox"/>	<input type="checkbox"/> Burning or Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/> Skin Rashes, Itching or Dry Skin
<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/> Incontinence	<input type="checkbox"/>	<input type="checkbox"/> Hair or Nail Changes
<input type="checkbox"/>	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/> Blood in Urine or Stool	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> Fainting
<input type="checkbox"/>	<input type="checkbox"/> Stroke/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/> Anxiety/Depression
<input type="checkbox"/>	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/> Night Sweats	<input type="checkbox"/>	<input type="checkbox"/> Memory Loss
<input type="checkbox"/>	<input type="checkbox"/> Swollen Glands/Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination or Thirst	<input type="checkbox"/>	<input type="checkbox"/> Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/> Autoimmune Disease			<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Cancer				
<input type="checkbox"/>	<input type="checkbox"/> Heartburn				

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

## 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 for **<10 minutes**.
- [4] This activity **causes me moderate pain** & I can do it for **<5 minutes**.
- [5] This activity **causes me severe pain** & I can do it for **<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/ washing	Washing dishes
Brushing teeth	Going to the bathroom
Putting on socks	Washing face
Getting in the bathtub	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	Bending to the side
Stooping	Reaching overhead
Bending backward	Bending forward
Reaching forward/back	Looking over shoulder
Kneeling	Other:

### Functional Activities:

Carrying objects <10 Lbs	Lifting grocery bags
Carrying objects >10 Lbs	Carrying bag/purse
Mowing lawn	Cleaning windows
Lifting weights	Sweeping
Mopping	Lifting objects off floor
Shoveling snow	Cleaning curtains
Climbing stairs	Raking leaves
Weeding	Pushing / pulling

### Social and Recreational Activities:

Bowling	Biking
Jogging	Hiking
Hunting/ fishing	Knitting/ crocheting
Swimming	Playing sport
Playing cards	Golfing
Gardening	Dancing
Yoga	Sewing
Exercising	Watching TV

### Difficulties with Traveling:

Driving for short periods of time	Getting into/ out of car
Driving for long periods of time	Riding for short periods of time
Riding in an airplane	Riding for long periods of time
Getting in/ out of bus or train	Other:

### 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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 occurs at a rate between one instance per one million, to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke in patients with a torcherous artery defect.

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 to 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.

Please Note: During both physical examinations and spinal adjustments, the doctors of Healthline Chiropractic will be adjusting the bones in the lumbosacral (lower back) and pelvic regions of the spine. If this method of adjustment makes you uncomfortable, then please inform the doctor so they can use a different approach.

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**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 the patient is a minor/child, a 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 with a copy of your x-rays in our files. The fee for copying your x-rays is \$20.00 per set of films. 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 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 that 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: \_\_\_\_\_