Last Name: First Name: Middle Initial:

Physical Address: City: State: Zip:   
Mailing Address: City: State: Zip:

Date of Birth: Age: Height: Weight:

Marital Status: Race: Gender: M/F Social Security #

Home Phone # Work # Cell#

E-mail Address: Employer: Occupation:

How did you hear about us?

**REASON FOR THIS VISIT**

*Briefly describe the reason for this visit.*

*Please include the impact it has had on your life and normal daily activities.*

Complaint:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did it start?

How long have you had it?

Have you had this problem before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this concern: Getting worse Staying the same Getting better

Is this concern: Mild Moderate Severe

What makes it **worse**?

What makes it **better**?

Is it **worse** in the: AM PM Is it **better** in the: AM PM

What does it feel like? Dull Achy Tight Stiff Sharp Stabbing Numb Tingling Shooting Burning Cramping Other:

Does this concern interfere with: Work Sleep Daily Routines Other Activities

Please Explain:

Have you seen other doctors about this concern? Yes No

Doctor’s name: Diagnosis:

Treatment: Results:

**CURRENT HEALTH**

Current Primary Care Physician: Last visit: Reason:

List any current injuries, illnesses, or diseases you have been diagnosed with (cancers, tumors, heart disease, infections, diabetes, aneurysms, etc.):

Medications: Blood Pressure Cholesterol Diabetes Pain Killers Muscle Relaxers

Other

Supplements (Please List):

Do you have any bodily implants? (pace maker, joints, screws, plates, breast implants, etc.)

Any current loss of bowel or bladder control? Yes No Current nutritional problems? Yes No

Any unexplained weight loss? Yes No Current fever? Yes No

Any Current seizures, paralysis, speech, vision problems? Yes No

If yes to any of the above, please explain:

**HEALTH HISTORY**

List any surgeries, operations, or other medical procedures (please give dates):

List any past injuries or serious injuries:

List and significant family illnesses:

Do you have any blood/lymph disorders? Yes No If yes, please list:

Do you have osteoporosis? Yes No Rheumatoid arthritis? Yes No

Please select one:

Never smoked Former smoker Current smoker Packs per day/week

Please select one:

Never drink alcohol Rarely drink Social drinker Heavy drinker Drinks per day/week

**CHIROPRACTIC EXPERIENCE**

Have you been to a chiropractor before? Yes  No

If yes, what was the reason for those visits?

Doctor’s name? Approximate date of last visit?

Results from last chiropractor?

**YOUR CONCERNS**



**GOALS FOR YOUR CARE**

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their body. The doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible:

***Relief Care:*** Symptomatic relief of pain or discomfort.

***Corrective Care:*** Correcting and relieving the cause of the problem as well as the symptom.

***Comprehensive Care:*** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

*I want the doctor to select the type of care appropriate for my condition.*

**ARE YOU AWARE THAT…**

Doctors of chiropractic care work with the nervous system? Yes No

The nervous system controls all bodily functions and systems? Yes No

Chiropractic is the largest natural healing profession in the world? Yes No

If chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

**FOR WOMEN ONLY**

Are you pregnant? Yes No If yes, when is your due date?

How many children have you had? Did you receive an epidural injections with either child?

Are you nursing? Yes No

Are you on birth control? Yes No

Date of last menstrual cycle? Date of onset of menopause?

Have you taken any hormone replacement therapies? Yes No

**Do you:** Experience painful periods? Yes No

Have irregular cycles? Yes No

**Consent to release information:** In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Care Chiropractic to release my medical records to:

Relationship: Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Relationship: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #

**RATE YOUR HEALTH**

Place an ‘**X**’ that denotes where you believe your current level of health to be.

Place an ‘**O**’ indicating where you would like your health to be.



**Patient’s Printed Name**:   
**Patient's Signature**: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(In the case the patient is a minor, parent or legal guardian must sign)

**AUTHORIZATION FOR CARE**

*I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.*

*I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor’s office will prepare and necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor’s office will be credited to my account on receipt.*

***The cost of the service you scheduled for will be charged if not notified for rescheduling or a cancellation.***

***AMIT appointments require notification 1 business day prior for rescheduling or cancellation in order for credit to be transferred to a future appointment or refunded.***

*It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

**TERMS OF ACCEPTANCE**

*When accepting a new patient who is seeking chiropractic, or other related therapies, it is essential for both the patient and doctor to be working towards the same objective. Chiropractic has only one goal, to work toward the cause, not the effect. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.*

*An* **adjustment** *is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our office method of correction is by specific adjustments to the spine.* **Health** *is a state of optimal physical, mental, and social well-being, not merely the absence of disease.* **Vertebral subluxation** *is a misalignment of one or more of the joints of the body. This can cause pain, or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body’s innate ability to maintain maximum health.*

*We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 subluxation.*

*I have read and fully understand the above statement. Any questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.*

**NOTICE OF PRIVACY POLICY**

*By law we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to the information.*

*Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.*

*As a patient you have a right to the following:*

* *You may request restrictions on your disclosures.*
* *You may inspect and receive copies of your records within 30 days with a request.*
* *You may request to view changes to your records.*
* *You may request corrections to your information.*
* *You may request confidential communication.*
* *You may request to a paper copy of this notice.*

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

* *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
* *Obtain payment from third party payers.*
* *Conduct normal healthcare operations such as quality assessments and physician’s certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.*

Patient’s Printed Name:   
Patient's Signature: Today's Date: \_\_\_\_\_\_\_\_\_\_

(In the case the patient is a minor, parent or legal guardian must sign)