

13315 Cortez Blvd Phone: 352-596-1900

Brooksville, FL. 34613 Fax: 352-596-9888

**Patient Application Form**

Welcome to our clinic. We specialize in assisting our patients in achieving their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the Doctor can let you if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Name

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date

**Electronic Health Records Intake Form**  
*In compliance with Medicare requirements for the Government EHR incentive program*

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](mailto:________________________@____________._______)

Preferred method of communication:  Email  Phone  Text  Mail

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Gender:  Male  Female Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 (MM) (DD) (YYYY)

*CMS requires providers to report both Race and Ethnicity*

Race:  American Indian or Alaskan Native  Asian  Black or African American  White or Caucasian  
  Native Hawaiian or Pacific Islander  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I decline to answer

Ethnicity:  Hispanic or Latino  Non-Hispanic or Latino  I decline to answer

Are you currently taking any medications?  Yes  No (Please include regularly used over-the-counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg 2x daily) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Do you have any medication allergies?  Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Reaction** | **Onset Date** | **Additional Comments** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

* I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of Chiropractic care)

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

Please list all past surgeries and associated dates:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any previous accidents and injuries, with associated dates:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any health health conditions not mentioned:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Lifestyle

Do you exercise?  Yes  No How often?  1x  2x  3x  4x  5x Per:  Week  Month

Smoker status?  Every day smoker  Occasional smoker  Former Smoker  Never smoked   
 If a smoker, what is your daily usage?  <5 daily  5-10 daily  11-15 daily  15-20 daily  >1 pack daily

Do you drink alcohol?  Yes  No What and how much?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee?  Yes  No How many cups per day? \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink soda?  Yes  No How many 12oz servings per day? \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink water?  Yes  No How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat fruits and vegetables?  Yes  No How many servings per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any supplements? (ie: vitamines, minerals, herbs)  Yes  No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Gender:\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Pregnant?  Yes  No If yes, how many weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of This Visit**

Reason for this visit – **Main Complaint**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition begin (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it begin:  Gradually  Suddenly

Is this related to a motor vehicle accident or injury at work?  Yes  No If yes, Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate your symptoms? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anything relieved your symptoms?  Yes  No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain:  Sharp  Dull  Ache  Burning  Throbbing  Spasm  Numbness  Tingling  Shooting

Does the pain radiate into your:  Arms  Hands  Legs  Feet Is the condition getting worse?  Yes  No

How often do you experience these symptoms throughout the day:  0%-25%  26%-50%  51%-75%  76%-100%

Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine  Other

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced this condition before?  Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who have you seen for this: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did they do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Second Complaint (if applicable)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition begin (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it begin:  Gradually  Suddenly

Is this related to a motor vehicle accident or injury at work?  Yes  No If yes, Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate your symptoms? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anything relieved your symptoms?  Yes  No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain:  Sharp  Dull  Ache  Burning  Throbbing  Spasm  Numbness  Tingling  Shooting

Does the pain radiate into your:  Arms  Hands  Legs  Feet Is the condition getting worse?  Yes  No

How often do you experience these symptoms throughout the day:  0%-25%  26%-50%  51%-75%  76%-100%

Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine  Other

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced this condition before?  Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who have you seen for this: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did they do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Third Complaint (if applicable)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition begin (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it begin:  Gradually  Suddenly

Is this related to a motor vehicle accident or injury at work?  Yes  No If yes, Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate your symptoms? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anything relieved your symptoms?  Yes  No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain:  Sharp  Dull  Ache  Burning  Throbbing  Spasm  Numbness  Tingling  Shooting

Does the pain radiate into your:  Arms  Hands  Legs  Feet Is the condition getting worse?  Yes  No

How often do you experience these symptoms throughout the day:  0%-25%  26%-50%  51%-75%  76%-100%

Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine  Other

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced this condition before?  Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who have you seen for this: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did they do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices  
Authorization for Use or Disclosure of Protected Health Information**

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to, or unless the law compels or requires us to. You may see your record or get more information about it by contacting one of our offices. We may use your health information in the following ways:

* We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, or provide assistance with your diagnoses or treatment from another provider or radiologist.
* We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials, and for reporting victims of abuse.
* We may call you by name in the reception area when the doctor is ready to see you.
* A postcard may be mailed to the address provided by you.
* When telephoning your home, we may leave a message on your answering machine or whomever answers when we call.
* We may include a photo of you on our referral wall.

You have the right to- request a copy of your records,ask to limit the information we share, amend your health information, or request a list of whom we share your records with. You have the right to revoke this authorization in writing at any time, except to the extent that the information has been released in reliance upon this authorization. Our office follows legal and ethical standards pursuant to HIPAA compliance at all times regarding your protected health information.  
Please advise our management if you believe your privacy rights have been violated.

By signing below, you consent to our use and disclosure of your protected healthcare information as indicated above and as required by law, and you acknowledge that you have read, understand, and agree to our Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Patient Name (Print) Patient Name (Sign)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Date

**Informed Consent**

Signing below indicates a request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physiotherapy and, if necessary, diagnostic x-rays on me by the Doctor of Chiropractic and/ or by any other office or clinic personal.

Possible Risks  
I understand and am informed that, as in all healthcare, in the practice of Chiropractic medicine there are some risks to treatment. These risks include but may not be limited to: stiffness, soreness, muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, and stroke. The ancillary procedures could produce skin irritations, burns, or minor complications.

Probability of Risks Occurring  
The risk of complications due to Chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single Aspirin tablet. The risk of cervicobrachial injury or stroke has been estimated at one in one million to one in twenty million, and can be reduced even further by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Other Treatment Options that Could Be Considered

* Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
* Medical care, typically anti-inflammatory drugs, tranquilizers, steroids, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
* Hospitalization in conjunction with medical care adds risk of virulent communicable disease in a significant number of cases.
* Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Consent  
I acknowledge I have discussed, or have had the opportunity to discuss, with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent waiver. I consent to the chiropractic treatments offered or recommended to me by my Chiropractor. I intend this consent to apply to all my present and future chiropractic care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Print Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Sign Patient Name

**Terms of Acceptance  
Procedures and Payment Policy**

When a person seeks chiropractic care and rehabilitative health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. It is important that each person understand both the objective and the method(s) that will be used to obtain this objective. By signing this form, you acknowledge that you have read, understand, and consent to the terms herein.

**Procedures**

* No Charge Consultation: This is a brief meeting between you and the Doctor to determining if you may benefit from the care we provide. There is no financial obligation in connection with this service.
* Clinical Exam: After your consultation, if the Doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic clinical exam will be recommended.
* X-Rays: Based on the exam findings, the Doctor may recommend selected x-rays be taken to aid in comprehensive diagnosis of your condition(s).
* Included in the cost of the clinical exam is a report of findings. This is where the Doctor presents his findings regarding your diagnostic testing. The Doctor will also explain what he feels would be the best and fastest approach to improve your health, based on your condition.
* Treatments may include: Spinal and extraspinal adjustments, joint manipulation, intersegmental traction, electric muscle stimulation, curve restoration traction, core muscle training, posture correction exercises, scoliosis correction therapy, cold laser therapy, rehabilitation therapy, spinal decompression, massage/ manual therapy, ice (cryotherapy), neuromuscular re-education, custom orthotics, analgesic rubs/ creams/ sprays, and nutritional recommendations and supplements.

**Payment Policy**

* Payment is expected at the time of service, unless prior arrangement has been made between you and the office.
* Health/ Automobile Insurance
  + Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify benefits of your particular coverage; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you, and you are responsible for any and all payment aside from benefit coverage approved by your insurance carrier.
  + We will file your insurance claim for you and do everything we can to ensure you receive proper reimbursement, if applicable.
  + If your policy has a deductible feature, it is due at the time of service.
  + We will do our very best to answer any questions you may have in regard to your insurance.
* There will be a $25 charge on all returned checks (plus the original amount of the check)

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

**No-call No-show Policy**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am aware that Family Chiropractic Health Centers may charge a   
“no-call/ no-show” fee of $25 for any missed appointment that is not cancelled or rescheduled in advance. I understand and agree that this fee must be paid before my treatment can resume, and is not payable by insurance.   
\*To avoid this fee, please notify our office at least 24 hours in advance of any appointment you may not be able to keep. We understand that life happens, and will help you reschedule as needed.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Office Staff Signature Date

**X-ray/ Diagnostic Testing Consent**

During the examination the Doctor may feel that additional scans and diagnostic tests will be needed in order to further assess and diagnose your condition. We would like to make you aware that, in those cases, additional x-rays and/ or diagnostic tests may be required in order to accurately diagnose your condition and administer treatment. In order to perform x-rays on any patient, our office requires consent for such tests to be performed.

Please choose one:

* I understand that my Doctor may need x-rays or diagnostic tests in order to diagnose my condition and I give my consent for all necessary scans and tests.
* I understand that my condition may require my Doctor to take x-rays to further diagnose my symptoms. I choose not to consent to additional scans or diagnostic tests at this time, and release the Doctor and Family Chiropractic Health Centers of all liabilities that may arise.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Office Staff Signature Date

**Pregnancy Release (Female Only)**

This is to certify that to the best of my knowledge I am not pregnant, and Family Chiropractic Health Centers has my permission to perform an x-ray evaluation. I understand that receiving x-rays while pregnant may cause complications to an unborn child and agree to hold Family Chiropractic Health Centers free from liability of such complications.

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

Estimated date of last menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_

**Please help us out and tell us how you found us:**

Drove by and saw sign?  Yes  No

Yellow pages listing  Yes  No  
  Verizon Yellow Pages  
  Yellow Book  
  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internet:  Facebook Advertisement  
  Google search  
  Yahoo search  
  Bing search  
  YP.com  
  Superpages.com  
  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you referred?  Yes  No

If yes, who referred you?

 Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  Attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  Another Doctor ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  Health Screening (where) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your referral include our phone number?  Yes  No

If No, where did you find our number?

 Called information  
  Internet search  
  Phone book  
  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_