CHIROPRACTIC INTAKE & HISTORY (13 and up)

compass CHIROPRACTIC

PATIENT INFORMATION (all fields required)

Name: _____ Age: _____ Sex: Male / Female Date of Birth: _____ /_____ /_____

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

Marital Status: Single / Married / Partnered / Divorced / Widowed Spouse's Name: _____ Number of Children: _____

First Name & Ages: _____

Phones: Home: _____ Cell: _____ Work: _____ Preferred Phone Number: Home / Cell / Work

Email: _____ Occupation: _____ Employer: _____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

What is your **#1 concern**? _____ Month & year it started? _____

Have you had it before? Y / N Is it getting Better, Worse or Same? B / W / S Is it? [ ] Constant or [ ] Come and Go

What has helped it? _____ What makes it worse? _____

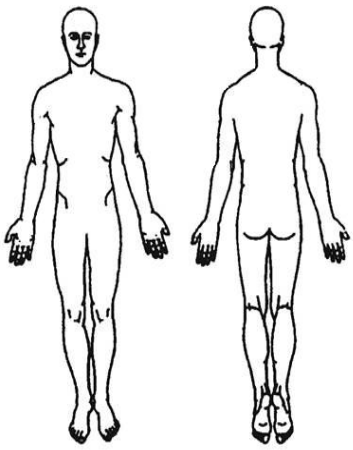
Is it? [ ] Sharp [ ] Dull [ ] Achy [ ] Numb [ ] Tingling [ ] Other? _____

Circle how severe is it? (least) 0 1 2 3 4 5 6 7 8 9 10 (worst) Do symptoms radiate? Y / N

How did it begin? [ ] Bending [ ] Lifting [ ] Twisting [ ] Fall [ ] Pushing/Pulling [ ] Car Accident [ ] Unknown

[ ] Other? _____

***Mark the site of symptoms on the diagram below.**



What is your **#2 concern**? _____ Month & year it started? _____

Have you had it before? Y / N Is it getting Better, Worse or Same? B / W / S Is it? [ ] Constant or [ ] Come and Go

What has helped it? _____ What makes it worse? _____

Is it? [ ] Sharp [ ] Dull [ ] Achy [ ] Numb [ ] Tingling [ ] Other? _____

Circle how severe is it? (least) 0 1 2 3 4 5 6 7 8 9 10 (worst) Do symptoms radiate? Y / N

How did it begin? [ ] Bending [ ] Lifting [ ] Twisting [ ] Fall [ ] Pushing/Pulling [ ] Car Accident [ ] Unknown

[ ] Other? _____

How committed are you to correcting these concerns? (Minimally) 1 2 3 4 5 6 7 8 9 10 (Highly)

IMPACT OF YOUR HEALTH CONCERNS

How is your condition / symptoms interfering with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

Have you seen any other healthcare providers for these conditions? Yes / No *If yes, what type of care, who, and when? _____

List all fractures, surgical operations and the corresponding years: _____

List ALL over the counter & prescription medications and why you are taking them: _____

How many car accidents have you had and when was the last? _____ Any other TRAUMA? _____

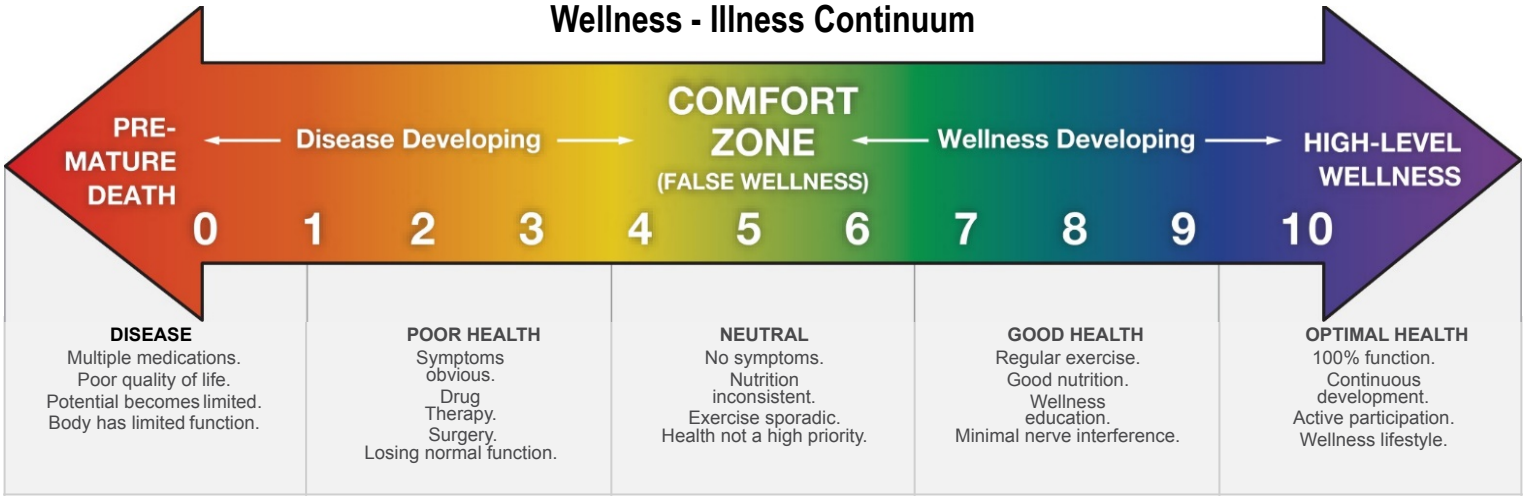
Patient Signature (or guardian if applicable): _____ **Date:** _____

HEALTH & ILLNESS HISTORY

Please CIRCLE any condition that have or have had.

Anxiety	*Depression*	*Headaches/Migraines*	*Ringing in the Ears*
Arteriosclerosis	*Diabetes*	*Heart Disease*	*Scoliosis*
Arthritis	*Digestive Issues*	*Hepatitis*	*Shoulder Issues*
Asthma	*Constipation*	*Hip Issues*	*Stroke*
Allergies	*Diarrhea*	*Immune Issues*	*TMJ Issues*
Back Pain	*GERD/Reflux*	*Lymphatic Issues*	*Urinary Issues*
Cardiovascular Issues	*IBS*	*Multiple Sclerosis*	*Osteoporosis*
Cancer	*Endocrine Issues (Thyroid)*	*Neck Pain*	*OTHER* _____
Circulation Issues	*Foot/Ankle Issues*	*Reproductive Issues*	_____
Childhood Illness	*Gout*	*Infertiility*	_____

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think best represents your health today? **0 1 2 3 4 5 6 7 8 9 10**

B. In what direction do you feel you are moving? **0 1 2 3 4 5 6 7 8 9 10**

GOALS

What are you hoping to get out of care in our office? In other words, what are your health goals?

Right now?_____

30 days from now? _____

One year from now? _____

Patient Signature (or guardian if applicable): _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

IF APPLICABLE:

SECONDARY INSURANCE CARRIER: _____ Insured Social: _____

Name of Insured _____ Insured Date of Birth _____

- Consultation- includes patient history. This service is complimentary.
- Assessment/Evaluation (new or established patient)- includes one or more of the following: thermography, range of motion, motion and/or static palpation, leg check. $25-$104.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand/instrument. $20-$60.
- X-rays- Specific x-ray views will be taken if necessary to evaluate the current state of your spine. These can also be used to indicate progress after a period of care. $30-80 per series.

Release of Authorization/Assignment of Benefits & Notice of Privacy Practices Acknowledgement

I understand that I may receive a statement of services received and paid for to submit to my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact he practice at any time to obtain a current copy of the Notice of Privacy Practices.

Terms of Acceptance & Consent to Care

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 point 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 the 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 subluxation(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 by 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 indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) 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, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

CHIROPRACTIC CARE, LIKE ALL 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 EXTREMELY RARE, FRACTURES OR BLOOD VESSEL INJURY.

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.

By my signature below, I have read and fully understand the above statements: the release of benefits, notice of privacy practices, terms of acceptance, and the consent to care. 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.

_____	_____	_____
Patient Name (printed)	**Signature (if applicable of guardian)**	**Date**