intouchchiropractic

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

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

Cell: _____ Home: _____ E-mail Address: _____

Employer: _____ Occupation: _____ Length of Employment: _____

Marital Status: S M W D Spouse's Name: _____ Children's Name(s): _____

Emergency Contact:_____Phone:_____

How did you hear about our office? _____Height_____Weight_____

Would you like us to check your insurance benefits? Yes No (please note that we are out-of-network providers)

Please describe in detail your **CURRENT** health symptoms: _____

_____

Where is your pain located? Right Left Does the pain travel? Yes No Where?_____

Please **circle** the pain as being: **Sharp Dull Shooting Numb Stabbing Tingly Constant Comes and Goes**
How serious do you think this problem is (circle one) **MINIMAL MODERATE SEVERE EXTREME**
List **treatments** you have received for this condition: _____
List ALL **injuries/trauma (including auto accidents)**: _____
List ALL **surgeries**: _____
Current **pharmaceutical drugs** you are taking and for what condition: _____
_____

Do you have breast implants? Yes No Do you have a permanent dental retainer(s)? Yes No

When was your last MRI? _____

Your Primary Doctor's Name:_____Phone Number:_____

Prior chiropractic care? Yes No Chiropractor's Name:_____Date Last Visit_____

What is your level of interest in **Non-Surgical Spinal Decompression** as a treatment option? Yes No Possibly

What is your level of interest in **NUCCA Upper Cervical Care** as a treatment option? Yes No Possibly

What is your level of interest in **Class 4 Laser** as a treatment option? Yes No Possibly

What is your level of interest in **Shockwave Therapy** as a treatment option? Yes No Possibly

Are you trying to avoid surgery? Yes No Possibly

The doctors will assess your case during your consultation to determine if you're a candidate for our care. Please note that we do not bill insurance carriers, and that we are out-of-network providers.

_____ _____
Patient/Guardian Signature Date

Consent to Physical Examination and X-Rays

Prior to receiving care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, and your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. 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.

During the consultation, the doctor may determine that an examination and x-rays are required for my care. I consent to an examination an x-rays in order to diagnose my condition. I accept and acknowledge ultimate responsibility for all charges incurred. Payment is due at time of service.

Patient/Guardian Signature: _____Date: _____

Patient Consent for Use & Disclosure of Protected Health 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.

- 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.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. 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/Guardian Signature: _____Date: _____

Females Only: Regarding the Possibility of Pregnancy

This is to certify that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, doctor's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way. I give the doctor and his/her associates my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Patient/Guardian Signature: _____Date: _____

Children Under 18: Consent to Evaluate and Adjust a Minor

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care, even when I am not present to observe such care.

Patient/Guardian Signature: _____Date: _____

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Please circle Yes or No for each of the following:

Long-term use of Immuno-Suppressant Drugs (e.g. prednisone)	Y	N	Seizure Disorder Triggered by Light (e.g. epilepsy)	Y	N
Use of Blood Thinners	Y	N	Steroid Injections (in the last month)	Y	N
Currently Pregnant	Y	N	Pacemaker	Y	N
Active Cancer	Y	N	Neurostimulation Device	Y	N
Laminectomy (at level of complaint)	Y	N	Joint Replacement	Y	N

I understand that treatment recommendations will be based on my health history and current health needs. This consent covers the entire course of care from all providers and staff in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I will notify the doctor(s) of any changes.

Patient/Guardian Signature_____ Date_____

Witness Signature_____