Confidential Patient Health Record Date:___/___/_____

Circle One: Divorced Married Single Separated Widowed Birth Date:___/___/_____ Age: _____

First: _____ Middle:_____ Last: _____ Gender: Male/ Female

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

Home Phone: _____ Cell Phone : _____

Social Security# :_____-_____-_____ Email Address :_____

Spouses Name: _____ Children (Ages):_____

Employer

Business Name:_____ Occupation/Job Title: _____

Business Phone: _____ Business Fax :_____

How did you hear about us? _____

Emergency Contact :_____ Phone : _____

Who is Responsible For Your Bill?

☐ Self ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Other (be specific) _____

Insurance : _____

Subscriber ID: _____ Group # : _____

Insured Person's Name: _____ Insured Person's Date of Birth : _____

If Work or Auto Related: Claim # _____

Contact Person Name: _____ Phone Number:_____

CURRENT HEALTH CONDITION

Chief Complaint (Why are you here today)?:

_____

_____

When did this condition begin?:_____

Has it ever occurred before? ☐ Yes ☐ No

When? _____

Is the condition: ☐ Work Related ☐ Auto Related ☐ No Injury

☐ Other: _____

Date of Accident: _____

Complaint/ Pain Onset Date: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If yes, Who? _____

Location of Office: _____

Type of Treatment: _____

Are you currently taking any medications? _____

_____

Do you wear any of the following?

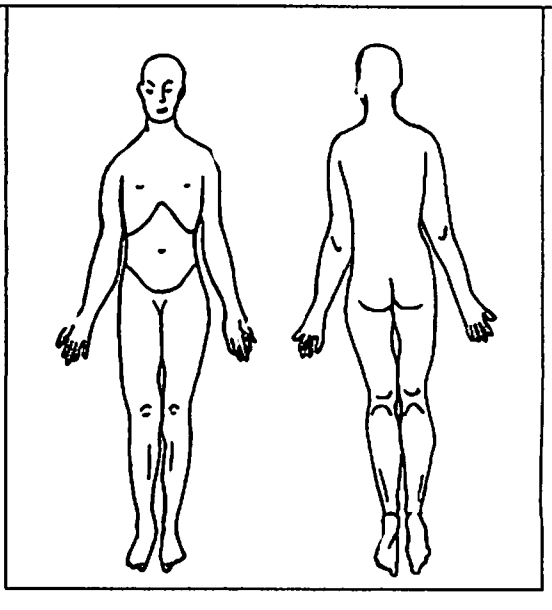
☐ Heel Lift ☐ Innersoles ☐ Arch Supports ☐ Orthotics

Please list any other conditions you feel we should know about:

_____

_____

Use the letters below to indicate the type and location of your sensations right now:
A= Ache B= Burning N= Numbness S= Stabbing
P =Pins and Needles O=Other



PATIENT HEALTH HISTORY- Please fill out all sections even if it seems unrelated to the purpose of your appointment. These problems can affect your overall course of care.

Have you had or currently experiencing any of the following?

Constitutional:

☐ Chills ☐ Drowsiness ☐ Fatigue ☐ Fever ☐ Weight Gain ☐ Weight Loss

Nervous System

☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors ☐ Unsteadiness of Gait

Illness:

☐ Allergies ☐ Alzheimers ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer
☐ Chicken Pox ☐ Crohn's ☐ CRPS (RSD) ☐ Depression ☐ Diabetes ☐ Ear Infections
☐ Emphysema ☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV
☐ Hypertension ☐ Influenzal Pneumonia ☐ Kidney Problems ☐ Liver Disease
☐ Lung Disease ☐ Lupus ☐ Multiple Sclerosis ☐ Parkinson's Disease
☐ Pleurisy ☐ Pneumonia ☐ Scoliosis ☐ Spina Bifida ☐ Stroke ☐ Suicide Attempts
☐ Thyroid Problems ☐ Vertigo ☐ Other _____

OB/GYN:

☐ Currently Pregnant ☐ Trying to get Pregnant
My Menses is : ☐ Regular ☐ Irregular ☐ Metaphase ☐ Menopause

Injuries:

☐ Back Injury ☐ Fracture ☐ Severe Fall ☐ Fracture ☐ Disability ☐ Head Injury
☐ Industrial Accident ☐ Joint Injury ☐ Severe Laceration ☐ MVA ☐ Soft Tissue Injury
☐ Other: _____

Family History: Please list any significant disease or illness

Father: _____ Mother: _____
Paternal Grandfather: _____ Paternal Grandmother: _____
Maternal Grandfather: _____ Maternal Grandfather: _____
Brother(s): _____ Sister(s): _____
Son(s): _____ Daughter(s): _____

Social History:

Alcohol Consumption: ☐ Never ☐ Social Consumption Only
Diet (check all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt
☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar
Drugs: ☐ Illegal Drugs ☐ IV Drugs ☐ Have not used drugs since _____
Tobacco: ☐ currently smoking # _____ ☐ Quit Smoking

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

I _____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is available upon request. I may also request a copy from this office at anytime via US mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Printed name of Patient Date

_____ _____
Signature of Patient, Parent, or legal guardian Witness

Payment Policy

___ **CASH:** Payment in full is expected at the time the service is done.

___ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment of benefits to this office for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance.

___ **ALL INSURANCE AND MEDICARE:** I hereby authorize this office to release any medical or incidental information that may be necessary for medical care or processing applications for financial benefits. If I receive payment from my insurance carrier during the period which the clinic has accepted assignment of benefits, I will bring the check into this office within 3 days of receipt and endorse it over to the office. Failure to do this may result in collection action. If I discontinue care for any reason other than discharge by the doctor, I will be responsible for any unpaid balance regardless of any claims submitted to my insurance company, at the time I discontinue care. This office does not promise that any insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be my responsibility to pay all the charges and pursue reimbursement from the insurance company on my own.

___ **CANCELLATION POLICY:** 24 hour notice must be given to cancel an appointment. In case of a short notice or no notice cancellation, a $25.00 cancellation fee will be charged.

___ **PAST DUE ACCOUNT POLICY:** After 60 days of non-payment, a $25.00 late fee will be added to my account to be compounded monthly. If necessary, my account will be turned over to a collections agency. As a last resort, the office will take legal action and all reasonable attorney and court fees incurred to collect fees due to this office will be added to my account and I will be responsible.

****I have read and understand the above and hereby agree to abide by the provisions as specified. Thank you for your cooperation and understanding.**

Patient Name:_____

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Information Release Form

Name: _____ Date: _____

Contact Preferences

By signing below I give permission to Whole Health Chiropractic to leave messages regarding my appointments, nutrition, or other health information via the following methods unless otherwise specified (strike through any methods you wish to not receive).

- Voice Message on Home Number / Cell Number / Business Number
- Text Message to provided number
- Email Message to provided email address
- Demand Force – email/text appointment reminders, newsletters, birthday wishes, etc.
    - Contact settings can be changed by following the instructions in an email or text.

Sign: _____ Date: _____

Digital Contact Release

I understand that Whole Health Chiropractic seeks to be available for questions and further clarification that may be required through email, texting, Facebook messages, or other digital outlets. I also understand that many of these forms may not be compliant with HIPAA (health information portability and accountability act) privacy standards for medical information. By signing I agree to allow Whole Health Chiropractic staff and doctors to discuss my health information with me via these non-secure forms. Nothing will be intentionally made public.

Sign: _____ Date: _____

*By refusing signature, you are declining contact through these forms and all health information questions must be addressed by appointment or phone call.

Testimonial Release

Whole Health Chiropractic enjoys using testimonials to aid in patient awareness and education. I understand that by becoming a patient, my story may be told in written or oral form including online media. I understand that I have the right to determine the level of information revealed that connects me to the testimony personally including my name, initials, location, etc.
I am aware that I can request the removal of my identifying information at any time.
By signing below I give Whole Health Chiropractic the authority to use my:
(Please select all that apply)

- My initials
- My name
- Nothing (pseudonym)
- Picture (if provided)

Sign: _____ Date: _____

Informed Consent to Chiropractic and Associated Care

SERVICES

–Chiropractic & Manual Therapy: Chiropractic treatment will involve the doctor using their hands or an instrument to move your joints in order to impact the nervous system, which regulates the entire body. This may or may not result in a harmless "pop" sound, depending on the various techniques used. Manual therapies, such as myofascial reconfiguration and trigger point release, will involve the use of hands or tools to break up adhesions and impact the nervous system. *Risks:* The risks of Chiropractic and manual therapies include mild skin irritation, soreness or bruising. Extremely rare risks can include fracture, strain, sprain, stroke, or possible injury to intervertebral discs, nerves, the spinal cord or arteries in the neck. These risks are diminished by performing a thorough history, risk assessment, and examination.

–Acupuncture & Meridian Therapy: Acupuncture involves the use of needles to stimulate points on the body known to produce certain effects. Meridian therapy is the study of the energy systems in the body as it pertains to Traditional Chinese and other Eastern medicine practices, which includes acupressure, auriculotherapy, and some use of traditional herbal principles. *Risks:* The risks of Acupuncture therapy include bruising, numbness or tingling near needle sites for a few days, dizziness or fainting. Rare risks include organ puncture or infection. These risks are diminished by using sterile, disposable needles and practicing in a clean and safe environment.

–Functional Nutrition & Supplementation: Nutritional evaluation may include history, signs and symptoms analysis, laboratory testing (serum, skin, hair, urine, stool, saliva, etc), muscle testing, and bio-resonance testing. Recommendations may include lifestyle modification, dietary changes, and supplement suggestions. *Risks*: The risks of dietary and certain supplemental care may result in diarrhea, constipation, nausea, gas, headache, rashes or allergic response, toxicities, and deficiencies. These are diminished by taking ownership of the foods eaten and supplements taken, following general recommendations, and informing my medical and other doctors of any nutritional supplements or dietary changes. A full history, including medications, family and social history, is taken.

–Bio-resonance Testing: Bio-resonance testing is a form of bio-feedback that allows deeper analysis of the human body. It is not licensed by the FDA to diagnose or treat any condition and is not employed by most practitioners in this way. All decisions are ultimately made based on clinical and laboratory information regarding therapies or nutritional recommendations.

Alternatives: Alternatives to Chiropractic and these associated methods include medical care (including medications and/or surgical procedures), massage therapy, physical therapy, over-the-counter medication, and other self-care.

Risks of Non-Treatment: Delay of treatment may allow for progression of the current condition or reduction in healing with greater likelihood of formation of chronic pain or lifestyle limitations.

CONSENT TO TREATMENT

I hereby desire and request care via the methods above from Whole Health Chiropractic for myself or the patient, named below, for whom I am legally responsible. I have been informed of the risks, benefits and alternatives to Chiropractic, manual therapy, acupuncture, nutritional and herbal modification, and biofeedback testing. I am aware it is my sole responsibility to inform my physician to the best of my knowledge any health history or risk information so that my care plan may be adjusted accordingly. I also accept responsibility for seeking appropriate care for any conditions that arise before or after beginning care, including but not limited to pregnancy, diabetes, and any communicable diseases.

I understand that my doctor at Whole Health Chiropractic cannot make any promises or guarantees regarding a cure or improvement of my condition. I understand they will share their professional opinion regarding potential results from Chiropractic care and will discuss treatment options with me, but it is my responsibility to remain informed and in charge of the direction of my care.

I have been given the opportunity to ask pertinent questions regarding the above information. I understand that I am responsible for payment at time of service. My signature signifies that I have read this document and understand its purpose. I release Whole Health Chiropractic and its employed or affiliated practitioners from any liability.

Patient Name (print): Legal Guardian (required to sign if patient under 18):

_____ _____

Sign: Date: Witness: Date:

_____ _____ _____ _____