**DATE:_____**

## ABOUT THE PATIENT

Name: _____
Address: _____

City: _____State: ____Zip: _____

Age: ___ Birthdate: ___/___/____ Gender: ☐M ☐F

Home Phone: _____ Work #: _____

Cell # _____

Emergency Contact/#:_____

Employer: _____Type of work: _____

Marital Status: ☐Mar. ☐Sing. ☐Div. ☐Wid.

Family M.D. or clinic: _____

How many children do you have? _____
Names: _____ Age: _____
_____ _____
_____ _____

E-mail address: _____
□ Check the box if you would like to receive important clinic updates, health and wellness information and much more through our online newsletter.

## ABOUT THE SPOUSE OR PARENTS

Name(s): _____
Employer: _____
Work Phone: _____
Type of Work: _____
Circle any condition a family member suffered with:
Spinal Problems, family member name: _____
Heart Condition, family member name: _____
Stroke, family member name:_____
Other: _____ family member name _____

## Insurance Information

**Policy Holder Information:**
**Name;_____**
**DOB:_____**
**ID#:_____**
**Group#:_____**
**Insurance Name:_____**
**_____**

## REASON FOR THIS VISIT

Describe the purpose of this visit: _____
_____

Is the purpose of this appointment related to:

☐Job ☐Auto ☐Fall ☐Sport ☐Daily Life
☐Chronic Discomfort ☐Home Injury ☐Other

Please explain _____

If job related, have you made a report of your accident to your employer? ☐Yes ☐No

When did this health challenge begin?_____

Has this: ☐gotten better ☐gotten worse
☐stayed constant ☐comes and goes

Does this interfere with: ☐Work ☐Sleep
☐Daily Routine ☐Other Activities

Explain: _____

Has this condition occurred before? ☐Y ☐N

Explain: _____

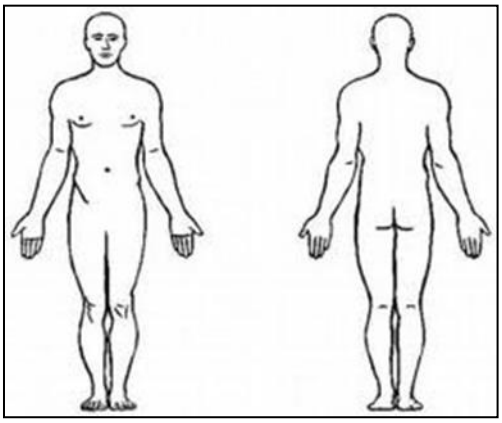
Have you seen other professionals for this?
☐Yes ☐No

Dr.'s Name(s): _____

Type of Treatment: _____

Results: _____

**Location of Symptoms**



## EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ☐Yes ☐No
Reason for those visits? _____

Previous Chiropractor's Name: _____

Approximate Date of Last Visit: _____
Has any adult in your family seen a Chiropractor? ☐Yes ☐No
Has any child in your family seen a Chiropractor? ☐Yes ☐No

## AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

- …Doctors of Chiropractic 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

## GOALS FOR MY 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 bodies. Your Doctor will weigh your needs and desires when recommending your treatment 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 symptoms
___**Comprehensive Care**—Caring for the **whole** body not just the symptomatic area. This works on achieving the highest state of health in your body.
___**I want the Doctor to select** the type of care appropriate for my condition.

## DECISIONS!

When I make big, important decisions, I generally:
☐___Research all the facts.
☐___Make the right choice instantly.
☐___Ask the advice of those I trust.
☐___Decide by how I feel about it.

## THE POWER OF THE BODY

**The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.**
This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical or emotional may cause these **subluxations**. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxations.**

## AUTHORIZATION FOR CARE

*I hereby authorize the Doctor(s) to work with my condition through the use of adjustments 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. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. 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 any 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.*

**Patient or Guardian Signature: _____**

**Date: _____**

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____

# Achieve Health Chiropractic Clinic

# Patient Health Information Consent Form

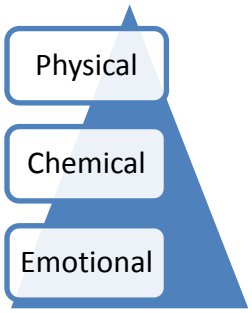
We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow their chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment and family members as needed. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. There may be a reasonable cost-based fee for photocopying, postage and preparation.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our office manager about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice.
9. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

**Signature of Patient** **Date**




# Stress Survey

**Your Name:** _____
**Today's Date:** _____
Your e-mail for our free newsletter:
_____ Please review each of these common stresses and circle when you experienced it in your life. Use **P for Past** and **C for Current**. If you expect or anticipate the possibility of experiencing this stress in the future, circle **F for Future**.

| ***Physical Stress is what we do to our bodies:*** | | | | ***Explanation:*** |
|---|---|---|---|---|
| 1.Forceps delivery | P | C | F | _____ |
| 2.Falls of any type | P | C | F | _____ |
| 3.Broken bones | P | C | F | _____ |
| 4.Strains or sprains | P | C | F | _____ |
| 5.Bad posture | P | C | F | _____ |
| 6.Poor sleeping habits | P | C | F | _____ |
| 7.Repetitive movements | P | C | F | _____ |
| 8.Sports injuries | P | C | F | _____ |
| 9.Heavy lifting and/or bending | P | C | F | _____ |
| 10.Overweight | P | C | F | _____ |

| ***Chemical Stress is what we do to our organs:*** | | | | ***Explanation:*** |
|---|---|---|---|---|
| 1.Take prescription medication | P | C | F | _____ |
| 2.Take over-the-counter drugs | P | C | F | _____ |
| 3.Consume alcohol | P | C | F | _____ |
| 4.Consume caffeine | P | C | F | _____ |
| 5.Use tobacco products | P | C | F | _____ |
| 6.Eat fast foods | P | C | F | _____ |
| 7.Use artificial sweeteners | P | C | F | _____ |
| 8.Bad diet (white flour & sugar) | P | C | F | _____ |
| 9.Exposed to environmental pollution | P | C | F | _____ |
| 10.Overweight | P | C | F | _____ |

| ***Emotional Stress is what we do to our minds:*** | | | | ***Explanation:*** |
|---|---|---|---|---|
| 1.Divorce or parents or spouse | P | C | F | _____ |
| 2.Death of a loved one | P | C | F | _____ |
| 3.Serious illness (self or loved one) | P | C | F | _____ |
| 4.Financial concerns | P | C | F | _____ |
| 5.WORRY | P | C | F | _____ |
| 6.Work environment | P | C | F | _____ |
| 7.Relationships | P | C | F | _____ |
| 8.Anger by you or at you | P | C | F | _____ |
| 9.Feel "not worthy" | P | C | F | _____ |
| 10.Put things off to the last minute | P | C | F | _____ |

Chronic stress forms the foundation of many health problems. Which of the 3 types of stress has had the greatest impact on your health and why? _____

# Foot Levelers Patient Information

Name_____ Date of Birth_____

Height _____ Weight _____

Shoe Size_____ Shoe Width: Narrow Average Wide X-Wide

Ordered Foot Levelers in the last 2 years: Yes No

**Shoe style** (circle all that apply)**:** Athletic (Laces)

Loafers (No laces)

Heels (1-2")

**Activity Level (**Please circle one):

| | |
|---|---|
| Light | (exercising 0-2 times a week) |
| Moderate | (exercising lightly 3 times a week) |
| Intense | (exercising heavily 4-7 times a week) |

**Circle all that apply to you:**

| | | | |
|---|---|---|---|
| Ball of foot or toe pain | L | R | Both |
| Arch Pain | L | R | Both |
| Heel Pain | L | R | Both |
| Lower Leg Pain | L | R | Both |
| Knee Pain | L | R | Both |
| Hip Pain | L | R | Both |
| Low Back Pain | L | R | Both |
| Postural Imbalance | L | R | Both |