BENNETT CHIROPRACTIC CLINIC

Patient Health History Today's Date: / /

First Name_____ Last Name_____

Address _____

City_____State_____Zip Code_____

Primary Phone_____Mobile Phone_____

Email_____

Permitted Contact Methods: ❑ Mobile Phone ❑ Text ❑ Email ❑Primary Phone

Date of Birth _____/_____/_____ **Age**_____ **Gender***(check one)* ❑Male ❑Female

Marital Status ❑Single ❑Married ❑Other #Children/Ages____/_____

Who should we contact in the event of an emergency? _____ Phone _____

Contact Address _____

Employment Status ❑Employed ❑FT Student ❑PT Student ❑Other ❑Retired ❑Self Employed

Employment Information

Occupation_____ Employer Name_____

Employer Address_____ Work Phone_____

Brief Job Description_____

Physical Stress Level ❑ Low ❑ Medium ❑ High May we contact you at work?❑Yes ❑No

Race *(check one)* ❑White❑Black/African American❑Hispanic ❑Other _____❑ I choose not to specify

Multi-Racial*(check one)* ❑Yes ❑No ❑Unknown

Ethnicity*(check one)* ❑Hispanic or Latino ❑Not Hispanic or Latino ❑ I choose not to specify

Preferred Language*(check one)*❑English❑Spanish❑Other_____❑ I choose not to specify

How did you hear about our office?:_____

Do you have a Primary Care Doctor? ❑ Yes ❑No

Primary Care Doctor Name _____Office Name _____

Problem Areas

Describe your problem(s):_____

_____

_____

How did your problem begin?_____

_____

When did it start?_____

❑Gradual over time ❑Suddenly

How severe is the pain from 0 to 10 with 10 being unbearable? 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain: ❑Aching ❑Sharp ❑Shooting ❑Stabbing ❑Burning ❑Tingling ❑Numbness

How often do you experience the symptoms?

❑ Constant ❑On and Off: ❑ < 25% ❑ 25-50% ❑ 50-75% ❑75-99% of the ❑ day ❑ week ❑ month

Does the pain radiate, shoot or travel? Where To?_____

What makes it better? (Times of day, movements, activities):_____

_____

What makes it worse? (Times of day, movements, activities):_____

_____

Medical History:

Current Medications: include start date, frequency, and dosage. If there are no current medications check here: ❑

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List any known drug allergies you have had to any medications. If no allergies are known, check here: ❑

_____

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ _____/____/____ 3) _____ _____/____/____

2) _____ _____/____/____ 4) _____ _____/____/____

Surgeries/Hospitalizations (include procedure, date, and hospital):

1) _____ _____/____/____ 3) _____ _____/____/____

2) _____ _____/____/____ 4) _____ _____/____/____

Do **you** now or have you ever had:

❑Heart Disease ❑Diabetes ❑Cancer❑Stroke❑High Blood Pressure ❑Thyroid Problems❑Tuberculosis❑Prostate Disorder❑Kidney Problems

❑Asthma ❑Ulcer ❑Seizure Disorder Other: _____

Do any of the following run in **your family**:

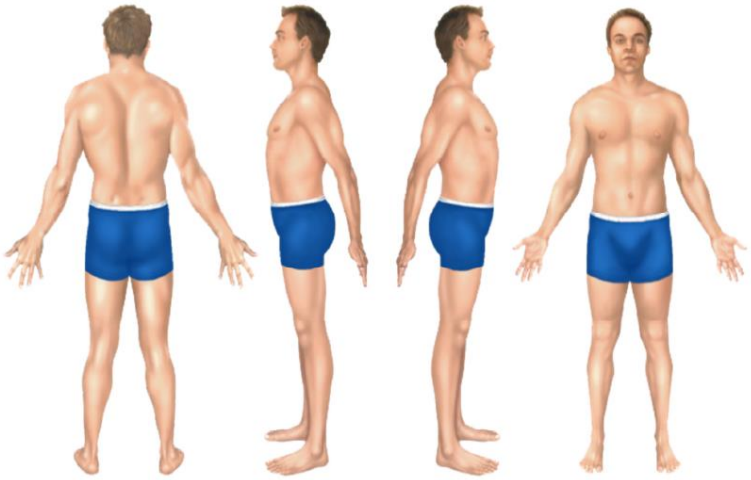
❑Heart Disease ❑Diabetes ❑Cancer❑Stroke❑High Blood Pressure ❑Thyroid Problems❑Tuberculosis❑Prostate Disorder❑Kidney Problems

❑Asthma ❑Ulcer ❑Seizure Disorder Other: _____

Pain Diagram

Instructions:By using the key below, indicate on the body diagram where you are experiencing the following symptoms. Also indicate your primary complaint with a 1, secondary complaint with a 2, and so on.

X X X X ACHING	0 0 0 0 PINS & NEEDLES
/ / / / / STABBING	- - - - NUMBNESS
+ + + + BURNING	<<<< OTHER



Indicate any present or past issues using the list below.

Past	Present	
❑	❑	Back Pain
❑	❑	Neck Pain
❑	❑	Muscle Pain
❑	❑	Arthritis
❑	❑	Poor Posture
❑	❑	Shoulder problem
❑	❑	Knee problem
❑	❑	Hip disorder
❑	❑	Osteoporosis
❑	❑	Scoliosis
❑	❑	TMJ Issues
❑	❑	Headaches
❑	❑	Loss of Strength
❑	❑	Numbness
❑	❑	Pins & Needles
❑	❑	Memory Loss
❑	❑	Dizziness
❑	❑	Depression
❑	❑	Anxiety
❑	❑	Hypertension
❑	❑	High Cholesterol
❑	❑	Angina
❑	❑	Palpitations
❑	❑	Fainting
❑	❑	Hypotension
❑	❑	Poor circulation
❑	❑	Bruising

Past	Present	
❑	❑	Asthma
❑	❑	Dyspnea
❑	❑	Apnea
❑	❑	Hay fever
❑	❑	Pneumonia
❑	❑	Ehphysema
❑	❑	Bronchitis
❑	❑	COPD
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Nausea/Vomiting
❑	❑	Reflux
❑	❑	Food Sensitivities
❑	❑	Dark/Bloody BM
❑	❑	Anorexia/Bulimia
❑	❑	Vision Loss
❑	❑	Blurred Vision
❑	❑	Hearing Loss
❑	❑	Loss of Smell
❑	❑	Ringing in Ears
❑	❑	Loss of Taste
❑	❑	Rash
❑	❑	Skin Cancer
❑	❑	Psoriasis

Past	Present	
❑	❑	Eczema
❑	❑	Hair Loss
❑	❑	Acne
❑	❑	Thyroid issues
❑	❑	Hypoglycemia
❑	❑	Swollen Glands
❑	❑	Immune Disorders
❑	❑	Frequent Infection
❑	❑	Low Energy
❑	❑	Frequent Urination
❑	❑	Bladder Leakage
❑	❑	Prostate Issues
❑	❑	Kidney Stones
❑	❑	Erectile Dysfunction
❑	❑	PMS Symptoms
❑	❑	Urinary Infections
❑	❑	Fatigue
❑	❑	Weakness
❑	❑	Sleeping problems
❑	❑	Poor appetite
❑	❑	Weight loss
❑	❑	Weight gain
❑	❑	Fainting
❑	❑	Low libido

Do you have health insurance? ❑ Yes ❑No ❑ Not Sure Company:_____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/_____
Does the policy holder have the insurance through his/her employer? □ YES □ NO

If yes, who is the employer? _____

FINANCIAL AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. **IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE**. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. I authorize the release of any information necessary to determine liability for payment.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me and to obtain reimbursement on any claim, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

LEGAL ASSIGNMENT OF BENEFITS, RELEASE OF MEDICAL AND PLAN DOCUMENTS, CONSENT TO TREAT

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Bennett Chiropractic Clinic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I,_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient's Signature: _____ Date: ____/____/_____

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

Printed Name – Patient or Representative

_____

Signature Date

Relationship to Patient (if other than patient) _____

Witness: _____

Printed Name – Clinic Representative

_____

Signature Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The hallmark of a chiropractic treatment is called spinal manipulative therapy or just spinal manipulation. Chiropractors use their hands to feel for restrictions in joint motion and "manipulate" or "adjust" the joint in order to restore motion. When you receive spinal manipulative therapy, you may hear a "crack" or "pop" in your back or neck. This popping sound is caused by the expulsion of gas in the joint. Other procedures used in our office include hot or cold packs, electrical muscle stimulation (EMS), and manual/massage therapy. Joint manipulation in the hands of a skilled chiropractor should be a very precise, gentle, and relatively painless procedure.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients (10-20%) may notice stiffness or soreness after the first few days of treatment (and especially after the first treatment). Usually this is a swelling reaction that can be alleviated using ice therapy and taking anti-inflammatory medication.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare" and the risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

The availability and nature of other treatment options: Other treatment options for your condition include:

- Self-administered over-the-counter analgesics and rest.
- Medical care and prescription medication such as anti-inflammatory, muscle relaxants, and pain meds.
- Physical Therapy
- Medical specialist—orthopedist, neurologist, rheumatologist
- Surgery

I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

The Consent was signed by: _____

Printed Name – Patient or Representative

_____

Signature Date

Relationship to Patient (if other than patient) _____

Witness: _____

Printed Name – Clinic Representative

_____

Signature Date