APEX CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Phone Carrier: _____

Best telephone number to reach you during the day: ☐ Cell ☐ Work ☐ Other: _____

Email: _____ Age: ____ DOB: _____ Height: ____ Weight: _____ Male/Female

Marital Status: ☐ S ☐ M ☐ W ☐ D How many children: ____ Names, Ages & Gender: _____

_____

Occupation: _____ Employer: _____ Phone: _____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Who may we thank for referring you in? FACEBOOK, INSTAGRAM, OTHER: _____

Health History

Main symptom you feel: _____ Average Pain Level: 0-10 (10 being worst) _____

What caused your condition: ☐ Auto Accident ☐ Work Accident ☐ Overexertion, Lifting, Pulling, Etc.

☐ Repetitive Movement/Posture ☐ Fall/Slip/Trip ☐ Gradual Onset ☐ Other: _____

DOI: _____ Date symptom appeared: _____ Is symptom: ☐ Better ☐ Worse ☐ Same

PLEASE LIST YOUR HEALTH CONCERNS BELOW Evaluation: _____ Member ID: _____

Health Concerns: List Worst First	Rate Severity 1=Mild 10=Unbearable	When did this episode start?	Did you have the condition before? when?	Did the problem begin with an injury?	Constant or Intermittent?

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE – CANCER – HEART DISEASE – SPINAL SURGERY – SPINAL FRACTURE – SCOLIOSIS – DIABETES

Have you seen any other doctors for this condition?

☐ Chiropractor ☐ Medical Doctor ☐ Other

If so, Who & When: _____

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List Surgeries and Date: _____

_____

List all MEDICATIONS you are currently taking: _____

When was your last AUTO ACCIDENT? _____

Have you had previous chiropractic care? ☐ YES ☐ NO If YES, When & Who: _____

Have you ever been knocked unconscious? ☐ YES ☐ NO

Fractured any bones? ☐ YES ☐ NO If YES, Please describe _____

Any other bodily trauma? _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES	ULCERS	BLADDER PROBLEMS	LUPUS
VERTIGO	CHEST PAINS	IRRITABLE BLADDER	FYBROMYALGIA
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD / ADHD
GRATING OF NECK	ARM PAIN	LEG NUMBNESS	GERD
TMJ	HAND NUMBNESS	FEET NUMBNESS	ANXIETY
NECK PAIN	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
MIGRAINES	HEART DISORDERS	HIP PAIN	EPILEPSY
STIFFNESS IN NECK	MID BACK PAIN	LEG PAINS	DISC PROBLEMS
CHRONIC SINUS	STOMACH DISORDERS	KNEE PAIN	INFERTILITY
THROAT ISSUES	NAUSEA	LIVER DISEASE	OTHER_____
THYROID ISSUES	REFLUX	MENSTRUAL ISSUES	_____
ANXIETY	DEPRESSION	ADDICTION	

The information I have provided is accurate and I know it will be used to determine appropriate chiropractic care. I authorize the performance of X-rays and all of their diagnostic and therapeutic procedures for myself and/or for my dependent(s). I acknowledge receipt of the Notice of Privacy Practices. I also give my consent to receive important email correspondence from this office.

Signature of responsible party: _____ Date: _____

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Level of Commitment Questionnaire

We assist individuals and their families in reaching their health goals. Whether your interest is reduced pain or you are committed to optimal function and true health, we are here to simplify the process. Please share with us your level of commitment to your health. This will assist us I understanding your personal situation and help guide Dr. Shane in creating your care recommendations.

Please mark the box that is appropriate for you with an 'X'.

☐ Relief

I am not committed to my overall health. I only have interest in managing my aches and pains. I realize that symptoms are the last thing to show up and the first thing to leave, so the progression of this process (the cause) will most likely continue.

☐ Correction

I want to go beyond my aches and pains and begin to stabilize. I want to stop this process from progressing. I want to restore and heal. I want to address and correct the underlying cause of my health concerns.

☐ Wellness

I am not experiencing any health concerns. I want to utilize chiropractic care as a means of prevention. I understand the benefits of regular chiropractic care and want it to be part of my wellness portfolio. I want to be proactive in my health.

☐ Doctor's Choice

I want the doctor to make the best recommendation for my care based on my subjective concerns and objective information collected during my examination. I need help and am looking for Dr. Shane to guide my journey.

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Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality Chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your inborn given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions please feel free to ask us.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc, and although rare, minor fractures have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures, provided at Apex Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name: _____ Today's date: _____

Sign your name: _____