APEX CHIROPRACTIC

Evaluation:	Member ID:

CONFIDENTIAL PATIENT INFORMATION

Name:	DOB:	State:
Address:	City:	Zip:
Home Phone:	Cell Phone:	Phone Carrier:
Email:		
Height: Weight:	Gender: ☐ Female ☐ Male	
Marital Status: ☐ S ☐ M ☐ W ☐ D	How many children:	
Names, Ages, & Gender:		
Occupation:	Employer:	Phone:
Spouse Name:	Employer:	Phone:
Emergency Contact:	Relation:	Phone:
How were you referred to our office? ☐ Facebook ☐ Instagram ☐ Google ☐ Other:		

HEALTH HISTORY

Main symptoms you feel:
Circle Average Pain Level:1 (lowest) - 10 (highest): 1 2 3 4 5 6 7 8 10
What caused your condition: ☐ Auto Accident ☐ Work Accident ☐ Overexertion ☐ Repetitive Movement / Posture ☐ Fall, Slip, Trip ☐ Gradual Onset Other:
Date of Incident: Date symptoms appeared:

Since your symptom appeared, how have these life categories changed?

1) Your quality time with family and friends WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT	**5) Your average number of sick days** WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT
2) Your overall well-being WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT	**6) Your digestive health** WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT
3) Your sleep WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT	**7) Your exercise ability** WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT
4) Your daily stress level WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT	**8) Your energy level** WORSE SAME SOME IMPROVEMENT MUCH IMPROVEMENT

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CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR HAD IN THE PAST

STROKE	CANCER	HEART DISEASE	
SPINAL SURGERY	SPINAL FRACTURE	SCOLIOSIS	DIABETES
Have you seen any other doctors for this condition: ☐ YES		☐ NO	
If so, who and when:			
List any surgeries and date of surgery:			
List any medications you are 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	
Have you fractured any bones: ☐ YES	☐ NO	Describe:	
Any other bodily trauma, please describe:			

CIRCLE ANY / ALL PROBLEMS THAT YOU HAVE HAD IN THE LAST 2 YEARS

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

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: _____

APEX
CHIROPRACTIC

CONSENT TO INITIAL 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.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____