

Health First Chiropractic & Wellness Center

PATIENT INFORMATION (Adult – 18+)

Please print clearly:

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

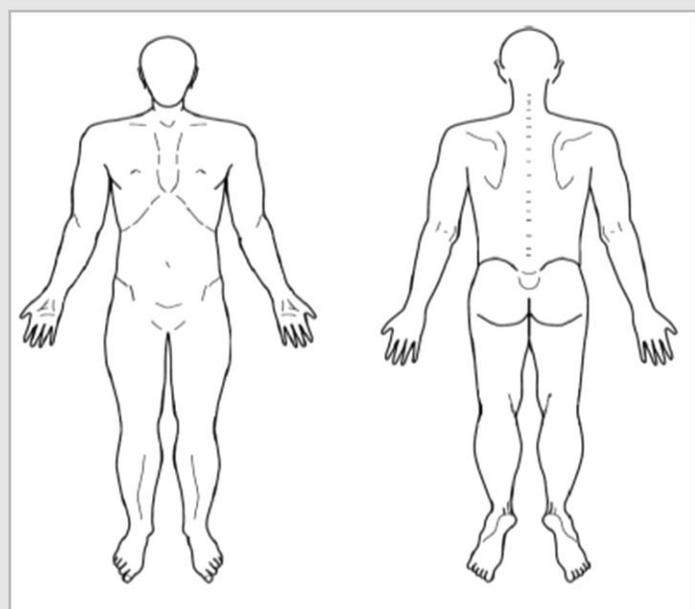
CELL #: (____) _____ - _____

HOME #: (____) _____ - _____

E-MAIL: _____

DATE OF BIRTH: ____/____/____ M / F

OCCUPATION: _____



STATUS: Single / Married / Divorced / Widow

Spouse's Name _____

EMERGENCY CONTACT:

Name _____

Phone#: (____) _____ - _____

CHILDREN: YES / NO

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Whom may we thank for referring you?

Primary reason you are seeking our help:

If you have any specific areas you would like us to address, please mark the area of concern on the above diagram.

Does the reason for your visit today involve:

Auto Accident claim? YES / NO

Workman's Compensation claim? YES / NO

Disability /Medicare/Medicaid claim? YES / NO

How long have you had this problem?

Have you been seen by a chiropractor before?

YES / NO

If yes, Who? _____

Reason for care? _____

Approximate dates of care: _____

Health First Chiropractic & Wellness Center

530 Madison Street - St. Charles, MO 63301

(636) 946-3600

MEDICAL HISTORY:

List all operations and approximate dates: _____

List all medications you are currently taking and why:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

FEMALES ONLY:

Are you or could you be pregnant? **YES / NO** When was your last period? _____

Please list any concerns you feel we need to know about: _____

What are you seeking to accomplish from our office? Check all that apply:

- Chiropractic Corrective Care:** Specific plan of chiropractic care and exercises to remove nerve interference and restore function to your spine and nervous system.
- Nutritional Consultation:** Areas of greatest concern: _____
- Movement:** Exercise and stretches to help you strengthen and stabilize your body.
- Innate Lifestyle Program:** Health specific classes with topics addressing optimal nutrition, functional movement and stress reduction.

INITIAL EACH LINE BELOW:

- I understand this office is not offering to treat symptoms and disease. I understand the purpose of my examination is to determine how to improve the overall health of my spine and nervous system. I hereby authorize the doctors at Health First Wellness Center and/or their assistants to perform my initial health examination.
- I understand this office **DOES NOT** participate in any provider network, accept **ANY** form of Insurance, Medicare/Medicaid, or third-party reimbursement.
- I understand that because the doctors do not participate in Medicare, if and when I am 65 years of age or older, I will receive a senior adjustment rate. However, I acknowledge that when I am 65 years of age or older, I will NOT be able to submit a claim to any insurance provider, including Medicare, Medicaid, or any third-party payer, for reimbursement.
- I clearly understand and agree that all service rendered to me are charged directly to me and I am responsible for payment.
- I understand that if I choose to use a credit or debit card for payment, I will be charged an additional 3.94% transactional fee.
- I understand by signing below, I agree to above terms, and certify that the information in this entire intake form is true and correct.

Patient Signature

Date

Review of Systems

Name: _____

Date: _____

1. General

- No Problems
- Fever or Chills
- Unexplained hair loss

2. Eyes

- No Problems
- Eye pain
- Blurred vision
- Loss of vision

3. Ears/Nose/Mouth/Throat

- No Problems
- Dizziness
- Dental Problems
- Swollen glands in neck
- Sore throat/pain with swallowing
- Mouth sores

4. Cardiovascular

- No Problems
- Chest Pain (sharp/crushing/heaviness)
- Heart racing (palpitations)
- Sudden shortness of breath at night or when lying down
- Leg pain in calf or thigh
- Aching/burning in legs
- Fainting spells
- Swelling of legs (edema)

5. Respiratory

- No Problems
- Shortness of breath
- Night sweats
- Cough/coughing up blood

6. Genitourinary

- No Problems
- Pain when urinating
- Urinating more frequent than usual
- Pain during sex
- Blood in urine
- Bladder infection/other infections
- Change in sex drive (libido)

7. Women

- No Problems
- Irregular periods
- 3 or more yeast infections in a year

8. Gastrointestinal

- No Problems
- Decreased appetite
- Nausea/vomiting
- Constipation
- Increased appetite
- Stomach pain
- Diarrhea

9. Musculoskeletal

- No Problems
- Joint pain
- Numbness, tingling in arms, legs, face
- Limited motion of arms, legs, back or neck
- Swelling/redness, if so where: _____

10. Neurological

- No Problems
- New headaches
- Headaches with vision changes
- Arm/leg weakness
- Repeated bad headaches
- Problems with memory or speech

11. Endocrine

- No Problems
- Thirsty all day
- Increased facial hair (females only)
- Weight gain/loss
- Intolerant to temperature changes

12. Lymph

- No Problems
- Swollen glands (armpit, groin, neck)

13. Skin

- No Problems
- Changes in skin
- Rash (palm of hands, sole of feet)
- Sores or rash on skin

14. Allergies

- No Problems
- Hives/skin rashes
- Allergic reaction to drugs
- Allergic reaction to foods

15. Other: _____

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Informed Consent for Chiropractic Examination and Care

Straight chiropractic care focuses on a single objective: to detect and correct vertebral subluxations. Vertebral subluxation is a misalignment of spinal bones that may interfere with nerve function, potentially affecting the body's natural ability to heal. Our goal is to support your body's innate healing process by addressing these misalignments through specific spinal adjustments. To avoid confusion or unmet expectations, it's essential that we share this common goal.

Scope of Practice

What We Do: We analyze the spine to identify vertebral subluxations and use specific chiropractic adjustments to correct them. This process aims to optimize nerve function and support your body's natural healing abilities. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom.

What We Do Not Do: We do not diagnose or treat diseases or medical conditions other than vertebral subluxations. We also do not provide advice on treatments prescribed by other healthcare providers.

Non-Chiropractic Findings: If we observe any unusual or non-chiropractic findings during your examination, we will inform you and recommend consulting a healthcare provider who specializes in that area.

Authorization for Examination and X-Rays

I authorize the chiropractor to perform a chiropractic examination to determine the presence of vertebral subluxations. If deemed necessary, I authorize the use of X-ray imaging. I agree that the Health First Chiropractic Clinic will be the custodian of any X-rays taken.

Patient Acknowledgment

I have read and fully understand the above information regarding the purpose, scope, and methods of straight chiropractic care.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Consent to Evaluate and Adjust a Minor Child

I, _____, as the parent or legal guardian of _____, have read and fully understand the terms outlined above. I grant permission for my child to receive a chiropractic examination and, if necessary, spinal adjustments.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Date: _____

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HIPAA Notice of Privacy Practices *(effective date Sept 1, 2025)*

Acknowledgment and Consent Form

I, _____ (Patient's Name), acknowledge and agree to the following by signing this consent:

Privacy Notice

Health First Chiropractic Clinic has offered me (upon request) a copy of its **HIPAA Privacy Notice**, which describes how my **Protected Health Information (PHI)** may be used and disclosed for treatment, payment, and healthcare operations. I understand that I may request a copy at any time and have been encouraged to review it carefully before signing this consent. The Privacy Notice also explains how my PHI is protected.

Use and Disclosure of PHI

Health First Chiropractic Clinic may use or disclose my PHI—including information related to my health and chiropractic care, such as the assessment and correction of vertebral subluxations—for purposes of treatment, obtaining payment, and healthcare operations (e.g., scheduling, billing, and quality improvement).

Right to Request Restrictions

I understand that I may request restrictions on how my PHI is used or disclosed for treatment, payment, or healthcare operations. While Health First Chiropractic Clinic is not required to agree to my request, any agreed-upon restrictions will be binding. All restriction requests must be submitted in writing.

Electronic Health Information

I understand and agree that my PHI and other Electronic Health Information (EHI) which may include, but is not limited to, medical records, billing records, diagnosis, treatment plans, lab results, imaging studies, and notes related to my care will be stored and managed electronically on a cloud-based platform chosen and utilized by Health First Chiropractic Clinic.

Consent for Communication via Mobile Phone and Email

I understand that by providing my mobile phone number and/or email address, I authorize Health First Chiropractic Clinic to use limited PHI—such as my name and appointment details—to contact me via text messages or emails. These communications may include appointment reminders, missed appointment notifications, or other practice-related messages. I understand that these communications may not be secure unless encrypted; I have the right to opt out or revoke this consent in writing at any time by contacting the office; and I understand that Health First Chiropractic Clinic uses secure systems whenever possible to protect my PHI.

Right to Revoke Consent

I understand this consent is valid for seven years. I understand that I may revoke this consent at any time by submitting a written request to Health First Chiropractic Clinic. The revocation will not affect any actions Health First Chiropractic Clinic has already taken based on my prior consent.

Consequences of Not Signing Consent or Revoking Consent

I understand that if I do not sign this consent, or revoke it, Health First Chiropractic Clinic will not provide treatment.

Changes to this Notice

Health First Wellness Center reserves the right to change its Notice of Privacy Practices and to apply the new notice to PHI already in its possession as well as to any information received in the future. A current copy of the Notice will be posted in the office and will include the effective date.

Acknowledgment and Signature

I have read and understand this consent form. All my questions about the use and disclosure of my protected health information have been answered to my satisfaction.

Name of Patient (Printed): _____

Signature of Patient: _____

Date Signed: ____ / ____ / ____

Name of Legal Guardian/Representative (if applicable): _____

Relationship with Patient: _____

Signature of Legal Guardian/Representative: _____

Date Signed: ____ / ____ / ____

Witness: _____

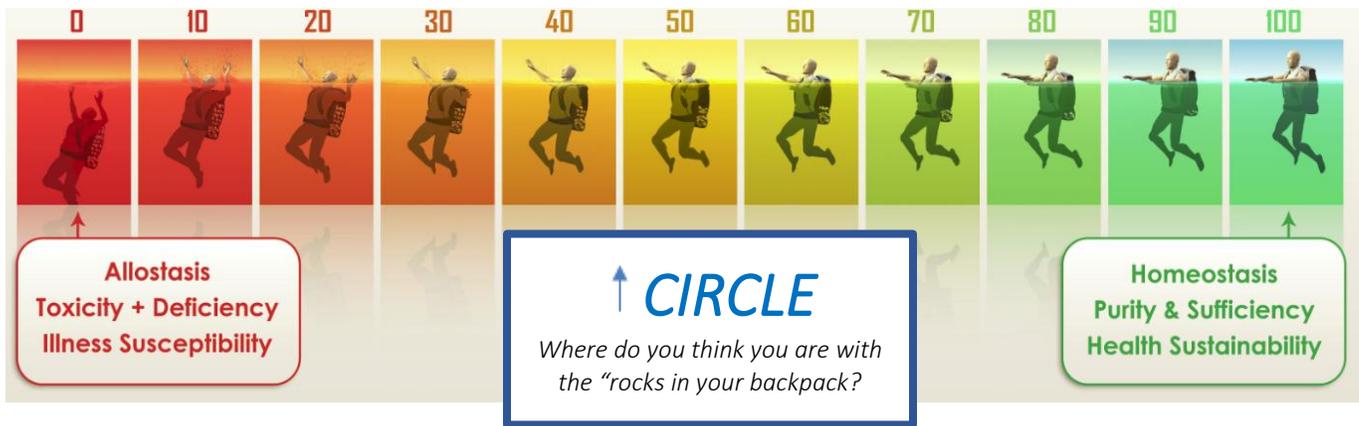
Name: _____

Date: _____

Current Health Profile

Everyone has “rocks” in our health backpack that can “sink” our future health. Every area we are deficient in how we eat, move, and think - we add a rock. Every area we are toxic in our lifestyle, i.e., lack of exercise, poor eating habits, mental/emotional stress – we add a rock. Our office is committed to identifying and helping you remove your rocks.

Where do you think you are?



Take the following health profile to help identify your health “rocks”.

Your honest answers will give us the ability to better address how to improve your future health.

Pain and Mobility	<i>Please circle your answers</i>					
Am I currently using medication to treat pain, inflammation, or headache?	NO (0)	YES (5)				
On average, over the past 30 days, has pain limited your ability to attend work/school?	Never/Very Rarely (0)	1-2 times per week (3)	3 times per week (5)	3+ times per week (10)		
I would rate my typical level of pain in the past week as: <i>(0= no pain at all; 5= worst pain possible)</i>	No Pain 0 (0)	1 (2)	2 (5)	3 (7)	4 (10)	High Pain 5 (15)
I would rate my ability to move (mobility/balance/strength) in the past week as: <i>(0= low/average movement ability; 5= high overall movement ability)</i>	Low Ability 0 (15)	1 (10)	2 (7)	3 (5)	4 (2)	High Ability 5 (0)
Pain and Mobility - Total Score						

You Are <u>What</u> You Eat	<i>Please circle your answers</i>			
How many meals do you include vegetables per week?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (3)	3+ times per week (0)
Do you buy more non-organic vegetables than organic ones?	NO (0)	YES (10)		
How often do you consume cereal, whole grain products, pasta, rice, or bread?	Never/Very Rarely (0)	1-2 times per week (5)	3-4 times per week (15)	4+ times per week (20)
Do you have any trouble with wheat or gluten?	NO (0)	YES (10)		
How often do you consume milk or cheese?	Never/Very Rarely (0)	1-2 times per week (5)	3 times per week (10)	3+ times per week (15)
Do you have any trouble with cow milk or cow milk products?	NO (0)	YES (10)		
How often do you use products containing hydrogenated/partially hydrogenated oils (Vegetable/Canola/Shortening, etc.)?	Never/Very Rarely (0)	Once per week (3)	Twice per week (5)	3+ times per week (10)
Do you regularly consume “low-fat” or “fat-free” products?	Never/Very Rarely (0)	Once per week (1)	Twice per week (3)	3+ times per week (5)
Do you eat nuts /seeds that are roasted and /or salted?	NO (0)	YES (3)		
Do you regularly eat/drink artificial sweeteners such as Sweet-n-Low, Equal, Splenda, or NutraSweet?	Never/Very Rarely (0)	Once per week (5)	Twice per week (10)	3+ times per week (20)
Do you use standard white table salt?	NO (0)	YES (5)		
Do you eat boxed or processed foods more than three times a week?	NO (0)	YES (10)		
How often do you eat from fast food restaurants like McDonald’s, Wendy’s, etc.?	Never/Very Rarely (0)	1-2 times per week (5)	3 times per week (10)	3+ times per week (20)
Do you drink city tap water?	NO (0)	YES (10)		
How often do you consume drinks containing caffeine and/or sugar (i.e., coffee, tea, sodas, fruit juices, corn syrup or added sugar)?	Never/Very Rarely (0)	1 cup per day (10)	2 cups per day (15)	More than 2 cups per day (20)
How often do you eat some form of store-bought dessert such as ice cream, cookies, donuts, cakes, or pies?	Never/Very Rarely (0)	Once per week (5)	Twice per week (10)	3+ times per week (15)
How much alcohol do you consume?	None (0)	Once per week (10)	Several per week (15)	Daily (20)
Do you take an Omega 3 supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)
Do you take a Vitamin D supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)
Do you take a Probiotic supplement?	Never/Very Rarely (10)	1-2 times per week (5)	3 times per week (1)	4+ times per week (0)
You are What you Eat - Total Score				

You are <u>When</u> You Eat	<i>Please circle your answers</i>			
Do you frequently skip meals?	NO (0)	YES (5)		
How many times is your breakfast primarily carbohydrates (toasted breads/cereal/oatmeal/pancakes, etc.)?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you often get hungry or crave sweets within two hours after eating meals?	NO (0)	YES (5)		
Do you have difficulty burning fat around your belly, hips, or thighs even with regular exercise?	NO (0)	YES (5)		
Do you eat your largest meal in the evening?	NO (0)	YES (5)		
Do you often eat or snack after 7PM?	NO (0)	YES (10)		
You are When You Eat -Total Score				

Please list all the OTC (over the counter) health supplements/dosages you are taking:

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Digestion	<i>Please circle your answers</i>			
How often do you experience lower abdominal bloating?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you frequently have loose stools or diarrhea?	No (0)	Once per week (5)	More than 3x per week (10)	
How often do you experience constipation or stools that are compact/hard to pass?	Never/Very Rarely (0)	1-2 times per week (1)	3 times per week (5)	3+ times per week (10)
Do you crave certain foods such as bread, chocolate, certain fruit, and dairy products if you have not eaten them in a day or two?	NO (0)	YES (10)		
Have you had your gallbladder removed?	NO (0)	YES (5)		
How often do you have indigestion or heartburn?	Never/Very Rarely (0)	1-2 times per week (3)	3 times per week (5)	More than 3x per week (10)
Do you have a history of using anti-acids, proton pump inhibitors, or anything that blocks acid?	NO (0)	YES (10)		
Do you get a headache after eating?	Never/Very Rarely (0)	1-2 times per week (5)	3+ times per week (10)	
How frequently do you have bowel movements?	Same as meal frequency (0)	1-2 times daily (1)	Every few days (5)	Only when taking something to help regularity (10)
Digestion -Total Score				

Possible Toxicity Indicators		<i>Please circle your answers</i>			
Do you take daily prescription medication?	Very Rarely (0)	1 to 3 different medications (50)	4 or more different medications (100)		
Would you consider your life to be:	Stress Free (0)	Mildly Stressful (10)	Very Stressful (40)		
Do you have or have you had dandruff in the past year?	NO (0)	YES (10)			
Do you suffer from any kind of skin condition (rash, eczema, psoriasis, etc.)?	NO (0)	YES (20)	If yes, what?		
Do you frequently experience itching in your ears or rectal region?	No (0)	1-2 days per week (10)	3+ days per week (20)		
Possible Toxicity Indicators - Total Score					

Sleep Wake Cycles		<i>Please circle your answers</i>			
How often do you wake up feeling un-rested and in need of more sleep?	Never/Very Rarely (0)	Once per week (1)	3 times per week (5)	More than 3x per week (10)	
Do you commonly go to bed after 10:00PM?	NO (0)	YES (10)			
Do you sleep on your stomach or in the fetal position?	NO (0)	YES (20)			
How often do you wake up at night between 2AM and 4AM and have a hard time falling back to sleep?	Never/Very Rarely (0)	3 times per week (10)	More than 3x per week (20)		
Sleep Wake Cycles - Total Score					

Exercise — Answer these questions based <u>on average, over the past 30 Days:</u>		<i>Please circle your answers</i>							
I perform at least 30 minutes of exercise the following number of DAYS per WEEK:	7 (0)	6 (3)	5 (5)	4 (7)	3 (10)	2 (13)	1 (15)	0 (20)	
I perform exercise with weights or resistance bands?	YES (0)	NO (10)							
I perform stretches for flexibility and range of motion?	YES (0)	NO (20)							
I typically SIT at work/school, commuting, and during my leisure time for the following number of combined HOURS per DAY?	Never/Very Rarely (0)	1-2 hours (5)	2-4 hours (10)	More than 6 hours (15)					
I would rate my current overall FUNCTIONAL ABILITY (mobility, balance, strength) to perform physical activities of daily life as:	Excellent (0)	Good (5)	Fair (10)	Very Low (20)					
Exercise - Total Score									

Lifestyle	<i>Please circle your answers</i>			
I understand my current health issues are affected by or a result of my lifestyle choices.	YES (0)	NO (20)		
Is there anything that you know you could do to improve your health, but you are not currently doing?	NO (0)	YES (10)		
Do you smoke?	NO (0)	YES (20)		
Do you consider yourself overweight?	NO (0)	YES (20)		
Do you consider yourself underweight?	NO (0)	YES (10)		
Do you have your nervous system evaluated by a chiropractor for subluxation/nerve interference at least every 2-4 weeks?	YES (0)	NO (20)		
During my lifetime, I have suffered the following number of SIGNIFICANT SPINAL TRAUMAS or INJURIES (from falls, accidents, work, or sport activities, etc.) that have resulted in neck or back pain, and/or the need to limit activities:	0 (0)	1 (10)	3 (15)	4+ (20)
Lifestyle - Total Score				
TOTALS:				
Pain and Mobility (page 1) - Total Score				
You are What you Eat (page 2) - Total Score				
You are When You Eat (page 3) - Total Score				
Digestion (page 3) - Total Score				
Possible Toxicity Indicators (page 4) - Total Score				
Sleep Wake Cycles (page 4) - Total Score				
Exercise (page 4) - Total Score				
Lifestyle (page 5) - Total Score				
Current Health Profile <u>Total Score</u>				