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: _____

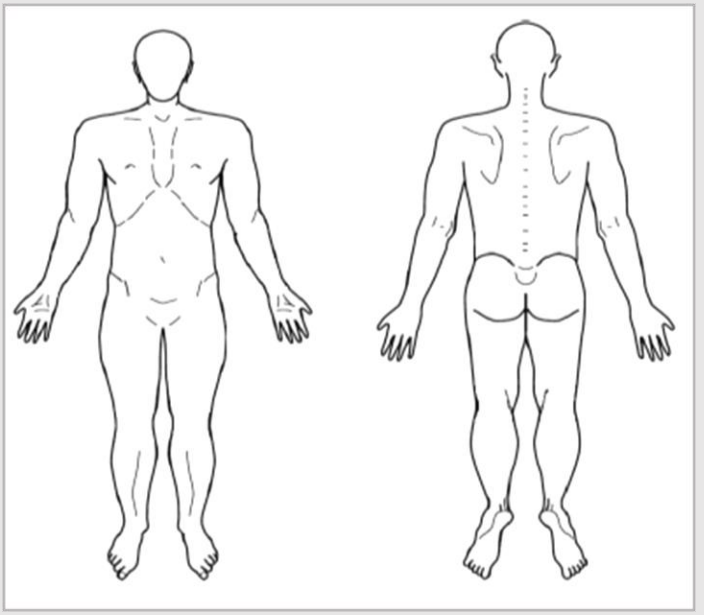
Name: _____ Age: _____

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.

Is this condition a result of an auto accident or workman's compensation 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: _____

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.
- ☐ **Nutrition:** Are you interested in learning about what God designed you to eat?
  Area of Greatest Concern: _____
- ☐ **Movement:** Are you interested in learning about how God designed you to move?
  Area of Concern: _____
- ☐ **Fitness Coach:** Are you interested in being recommended to a Fitness / Rehab Trainer? Are you interested in rehabilitation of a particular joint or injury recovery?
  Area of Concern: _____
- ☐ **Massage Therapy:** Are you interested in releasing muscle tension, creating mental relaxation as well as many other benefits of massage therapy?
- ☐ **Think Well:** Are you interested in learning about how God designed you to think so that you can alleviate "Thought Stressors" that negatively affect your well-being?
- ☐ **Hair Tissue Mineral Analysis test:** Are you interested in finding out if you have toxicities or deficiencies that could also be affecting your sleep, hormones and your energy levels?
- ☐ **Ideal Body Weight:** Are you interested in learning how to reach and maintain your optimal body weight?

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 clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I hereby authorize the doctors at Health First Wellness Center and/or their assistants to perform my initial health examination. I 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: _____

_____

Health First Wellness Chiropractic Clinic

Palmer Specific Chiropractic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND
(Patient's Name)
AGREE AS FOLLOWS:

1. The Practice's Privacy notice will be offered to me (upon request) prior to my signing this Consent. The Privacy notice includes a complete description of the uses and /or disclosures of my *protected health information* ("PHI") necessary for the Practice to provide treatment of me, and also necessary for the Practice to obtain payment of that treatment and to carry out its' health care operations. The practice explained to me that the Privacy notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its' privacy practices that are described in its' Privacy notice, in accordance with applicable law.
3. The Practice may use and /or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific health care operations.
4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice had already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship

Date Signed _____/_____ /_____ Witness: _____

Health First Chiropractic Clinic
Palmer Specific Chiropractic

Thank you for choosing Health First Chiropractic. We appreciate your trust and confidence in us. Our Purpose is "To educate and adjust as many families as possible toward optimal health through natural chiropractic care." Our Mission is to change the health of our community one family at a time.

We are very serious about your health and that of your family. Subluxations (nerve interference) greatly decrease your body's health potential and rob you of your quality of life. We will ask you to be as dedicated as we are to allow chiropractic to be a major factor in your journey to health.

Insurance Coverage - We have been asked to join many of the HMO\PPO organizations in the area; we respectfully declined theses offers after finding out they drastically limit the quality of your care. To be able to offer you more affordable care, it is our policy not to bill health insurance companies. All our practice members pay us directly; we will provide you with a "super bill" for you to submit to your insurance company. It is a good idea to contact your insurance company and find out what your policy coverage is before you begin care. If your insurance company requires more documentation than a "super bill", there is a separate service fee for each visit. Payment in full is always appreciated; however, affordable payment plans are always available for those who need them.

If you have not attended our "New Patient Orientation" please do so. This class provides you with information about all the services offered at our office. The purpose of the orientation is to answer questions about your health, to explain how your body heals and to share with you the knowledge that will allow you to receive the most from your chiropractic care. The orientation is also great opportunity for your friends and family to ask questions and better understand the benefits of corrective chiropractic care. Patients who truly understand how and why chiropractic works always get better results.

God has blessed us with Chiropractic. It is our privilege to share this with you. Please relax and enjoy as you learn how chiropractic can change your life.

I have read and understand the above office policy.

Patient Signature:_____ Date:_____

Health First Chiropractic Clinic
Palmer Specific Chiropractic

This Document Constitutes Informed Consent for Chiropractic Examination and Care

When a patient seeks straight chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Straight chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The Vertebral subluxation is the misalignment of spinal bones causing interference to the mental impulses traveling over the nerve pathways. The objective of straight chiropractic is to analyze the spine and locate and correct these vertebral subluxations. The straight chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE, is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I hereby authorize the doctor to perform a chiropractic examination to determine the presence of vertebral subluxation.

I hereby authorize the taking of x-ray films if necessary. I further agree that the above-mentioned doctor shall be the custodian of these x-rays.

All questions regarding the doctor's objective pertaining to detection of vertebral subluxation have been answered to my complete satisfaction.

I, _____ have read and fully understand the above statement.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I_____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination and adjustment if necessary.

_____ _____
(SIGNATURE) (DATE)