HEALING TOUCH CHIROPRACTIC

DOWNLOAD BEFORE COMPLETING OR YOUR CHANGES WILL NOT BE SAVED!

Today's date:	Patient Number

Vital Information				
Patient's Name		I prefer to be called		
Marital Status	Spouse/Partner Name	Birth date:	Age:	
Adderss Street	City	State	Zip	
Email	Home Phone:	May we leave a message? ☐ Yes ☐ No		
	Cell Phone:	May we leave a message? ☐ Yes ☐ No		
Occupation	Employer	Employer Phone:	May we leave a message? ☐ Yes ☐ No	
Do you have any children? ☐ Yes ☐ No	How Many?	Names & Ages of all Children		
Do they have any health conditions that you are aware of?				
Who can we thank for referring you to Healing Touch Chiropractic?		Have you ever been adjusted by a chiropractor before? ☐ Yes ☐ No		
Who and where?		Date of last adjustment		
Do you have a Primary Care Provider? ☐ Yes ☐ No		Who & Where?	Have you seen the above provider(s) for the same reason you are seeing us today? ☐ Yes ☐ No	
If not, what for?				
Additional comment (s)				

Emergency Contact			
Name	Relationship	Phone Number	Alternate Phone Number

WELLNESS PROFILE

QUESTIONS FOR WOMEN

☐	Past Pregnancy	☐	Current Pregnancy	☐	Breastfeeding
☐	Birth control pills/patch/ring	☐	Painful periods	☐	Irregular cycles
☐	Fatigue	☐	Anxiety/Depression	☐	PMS
☐	Weight Changes	Date of last menstrual period			
On a scale of 1 -10, with 10 being the highest, rate your commitment in helping us solve this problem.					

Your main complaint?	
Any other complaints?	
How long have you suffered with this problem?	Does handling this problem cause stress for you?
What have you tried to do to get rid of this problem that DID NOT work?	
Have you become discouraged about handling this problem?	☐ No ☐ Yes
How does this problem interfere with work?	
How does this problem interfere with family?	
How does this problem interfere with hobbies?	
How does this problem interfere with life?	
What do you do that makes this problem worse?	
What gives you some temporary relief?	
What is the pattern of this problem? ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic	
What is the effect it has on your body functions?	
How did it start?	
Are you on any type of medication? ☐ Yes ☐ No	If yes, please list:
Could your problem have been caused by an injury at work? ☐ Yes ☐ No	If yes, please give us the details:

System Challenges

Has your body communicated any of the following to you? While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.

☐	Headaches	☐	Heart Conditions	☐	Anxiety
☐	Allergies	☐	High Blood Pressure	☐	Depression/Nervousness
☐	Ringing in Ears	☐	Cholesterol	☐	Mood Swings
☐	Vertigo	☐	Anemia	☐	ADD/ADHD
☐	Rashes/Eczema	☐	Numbness in Arms/Legs	☐	Vision/Hearing Changes
☐	Sinus Problems	☐	Cold Hands/Feet	☐	Stroke
☐	Constipation/Diarrhea/Gas	☐	Urinary Changes	☐	Hypo/Hyper Thyroid
☐	Digestions Problems	☐	Weight Changes	☐	Prostate Changes
☐	Ulcers	☐	Sweats/Chills	☐	Chest Pain
☐	Low Back Pain	☐	Night Sweats	☐	Loss of Smell or Taste
☐	Neck Pain	☐	Dizziness	☐	Stomach Problems
☐	Tension Across Top of Shoulders	☐	Cancer	☐	HIV
☐	Tension Between Shoulder Blades	☐	Fatigue	☐	PMS
☐	Shortness of Breath	☐	Asthma	☐	Fever
☐	Loss of Sleep	☐	Arthritis	☐	Diabetes
☐	Heartburn	☐	Other	☐	

Stress Profile

Chiropractic is based upon the location and adjustment of vertebral subluxations. Subluxations are caused by any stress your body cannot properly perceive, adapt to, or integrate. These stresses may be physical, chemical, or emotional/mental in nature. Please circle the stresses that you've experienced as a child, teen, and adult.

Physical Stress	Child	Teen	Adult	None	Explain
Birth Difficulty (as a Mother or Child)	☐	☐	☐	☐	
Serious Slips/Falls	☐	☐	☐	☐	
Car Accidents	☐	☐	☐	☐	
Sports Injuries	☐	☐	☐	☐	
List Sports	☐	☐	☐	☐	
Physical Abuse	☐	☐	☐	☐	
Work Injuries	☐	☐	☐	☐	
Poor Posture	☐	☐	☐	☐	
Sitting on Your Wallet for Years	☐	☐	☐	☐	
Not Enough/Poor Sleep	☐	☐	☐	☐	
Extensive Computer Work	☐	☐	☐	☐	
Carrying Heavy Purse/Bookbag/Child	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Repetitive Lifting/Bending	☐	☐	☐	☐	
Driving for Many Hours	☐	☐	☐	☐	

Continuous Standing/Sitting	☐	☐	☐	☐	
Hospitalization	☐	☐	☐	☐	
Bone Fracture	☐	☐	☐	☐	
Surgery	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Emotional Stress:					**Explain**
Difficult Break-Up/Divorce	☐	☐	☐	☐	
High Stress Career	☐	☐	☐	☐	
High Family Stress	☐	☐	☐	☐	
Money	☐	☐	☐	☐	
Recurrent Physical/ Mental Illness	☐	☐	☐	☐	
Fast Paced Life	☐	☐	☐	☐	
Hold in Feelings	☐	☐	☐	☐	
Quick Tempered	☐	☐	☐	☐	
Verbal/Emotional Abuse	☐	☐	☐	☐	
Perfectionist	☐	☐	☐	☐	
Body Image Issues	☐	☐	☐	☐	
Made Fun Of/Teased	☐	☐	☐	☐	
Sickness or Loss of Loved One	☐	☐	☐	☐	
Difficulty Letting Go of Control	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Chemical Stress	**Child**	**Teen**	**Adult**	**None**	**Explain**
Environment (i.e. Poor Air/Water)	☐	☐	☐	☐	
Smoker/Second Hand Smoke	☐	☐	☐	☐	
High Sugar Consumption	☐	☐	☐	☐	
Poor Diet	☐	☐	☐	☐	
Caffeine	☐	☐	☐	☐	
Artificial Sweeteners	☐	☐	☐	☐	
Energy Drinks	☐	☐	☐	☐	
Vaccinations	☐	☐	☐	☐	
Prescription Drugs	☐	☐	☐	☐	
Over the Counter Drugs (i.e. Advil, etc.)	☐	☐	☐	☐	
Recreational Drugs	☐	☐	☐	☐	
Alcohol Use	☐	☐	☐	☐	
Antibiotics	☐	☐	☐	☐	
Work with Chemicals	☐	☐	☐	☐	
Poisoning	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Family Health History

Condition	Father	Mother	Spouse	You	Siblings			Children			
ADHD	Age	Age	Age	Age	Age	Age	Age	Age	Age	Age	Age
Allergies											
Arthritis											
Asthma											
Autism											
Back Trouble											
Bed Wetting											
Bursitis											
Cancer											
Chest Pain											
Colic											
Constipation											
Crohns Disease											
Depression											
Diabetes											
Diarrhea											
Disc Problems											

Family Health History

Condition	Father	Mother	Spouse	You	Siblings			Children			
Down Syndrome											
Ear Infection											
Emotion Issues											
Emphysema											
Epilepsy											
Headaches											
Migraines											
Heartburn											
Heart Trouble											
High Blood											
Pressure											
IBS											
Indigestion											
Infertility											
Insomnia											
Kidney Trouble											
Neck Pain											
Neuritis											
Nervousness											
Pinched Nerve											
Scoliosis											
Sinus Trouble											
Additional Comments:											

NOTICE OF HEALTH CARE AUTHORIZATION & PRIVACY POLICY

The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

- I give permission to Healing Touch Chiropractic to conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care.
- I give permission to use my physical address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If Healing Touch Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Healing Touch Chiropractic to obtain payment from third party payers, if applicable.
- I give permission to Healing Touch Chiropractic to use my name and photograph on their welcome board, referral board, bulletin board and other informational material such as their brochure, website, social media sites and articles in print media.
- I give permission to Healing Touch Chiropractic to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.
- I give Healing Touch Chiropractic permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- **You may request restrictions on your disclosures.**
- **You may inspect and receive copies of your records within 30 days of a request.**
- **You may request to view changes to your records.**

By signing this form you are giving Healing Touch Chiropractic permission to use and disclose your Protected Health Information in accordance with the directives listed above.
The use of this format is intended to make your experience at Healing Touch Chiropractic more efficient and productive as well as to enhance your access to quality of Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Healing Touch Chiropractic plus 7 years unless revoked by me. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

I have read and understand this Healthcare Authorization Form. My signature below represents agreement with these practices.
Name

Signature **Date**

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.
To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. **Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.**
B. **Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s).**
C. **The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to the spine.**
D. **is a safe, effective procedure applied over one-million times each day in the United States by doctors of chiropractic. Like all forms of health care, while offering considerable benefit, chiropractic may also provide some level of risk. This level of risk is minimal, yet injury can occur in rare cases.**
E. **A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during This process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.**
F. **Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.**
G. **Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.**
H. **We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.**

I, have read and fully understand the above statements. I understand there may be risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.
Patient or Guardian Signature Date

Name Click here to enter text.

Our Fee Structure
Please note our fees for your initial visit: Consultation, exam and nervous system scan: $149 **X-rays, if applicable: Fee paid to radiology provider** **Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.** **Also, note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, will be complimentary.** **I, have completely read an understoodhe above statement concerning fees and choose to receive care.** **Signature Date**

Financial Policy
Recommendations for care are based on necessity and not insurance benefits. Please understand that insurance companies pay for sick-care, not wellness care as provided by Healing Touch Chiropractic. Your insurance policy is between you and your insurance company, not between your insurance company and us. You understand that we do not guarantee that your insurance company will pay for treatments rendered in this clinic and understanding that the cost for service rendered to you by Healing Touch Chiropractic is your personal responsibility. ***Please note that Healing Touch Chiropractic is a non-payable provider for Blue Cross Blue Shield** **I CLEARLY UNDERSTAND AND AGREE that I am responsible for all bills incurred at this office relating to my care. I also understand that I may suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable. I agree that if I fail to provide Healing Touch Chiropractic with payments made in my name for services rendered at Healing Touch, I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.** **I, have completely read and understood the above statement concerning insurance and choose to receive care.** Signature **Date**