

Life Story

Vital Information

Name _____ Date ____/____/____

I prefer to be called _____

Address _____

City _____ State _____ Zip _____

Home # _____ - _____ - _____ Work # _____ - _____ - _____ Cell # _____ - _____ - _____

Preferred Contact # h | w | c _____ Email _____

Birthday ____/____/____ Age _____ SSN _____ - _____ - _____

Occupation _____ Employer _____

Marital Status Married Single Widowed

Spouse/Partner Name _____

Do you have children? y | n How many? _____

Names & Ages of all Children _____

Do they have any health problems that you are aware of? _____

Who can we thank for referring you to Healing Touch Chiropractic?

Have you ever been adjusted by a Chiropractor? y | n

Who & Where? _____ Date of last adjustment? ____/____/____

Do you have a Primary Care Provider? y | n

Who & Where? _____

Have you seen the above provider(s) for the same reason you are seeing us today? y | n

If not, what for? _____

Additional comment (s) _____

Person to contact in case of emergency: _____

Relationship: _____ Phone # _____ - _____ - _____

Questions for Women

- Past pregnancy
- Birth control pills/patch/ring
- Fatigue
- Weight Changes

- Currently pregnant
- Painful periods
- Anxiety/Depression

Date of last menstrual period _____

- Breast-feeding
- Irregular cycles
- PMS

Commitment Level

On a scale of 1 -10, with 10 being the highest, rate your commitment in helping us solve this problem.

1 2 3 4 5 6 7 8 9 10

Name: _____

Vital Information

Your main complaint: _____

Any other complaints: _____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work?

Have you become discouraged about handling this problem? y | n

How does this problem interfere with the following areas?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? y | n

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? y | n

If yes, please list: _____

Could your problem have been caused by an injury at work? y | n

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.

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

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Name: _____

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)	C	T	A	N	_____
Serious Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
List Sports	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on Your Wallet for Years	C	T	A	N	_____
Not Enough/Poor Sleep	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Standing/Sitting	C	T	A	N	_____
Hospitalization	C	T	A	N	_____
Bone Fracture	C	T	A	N	_____
Surgery	C	T	A	N	_____
Other	C	T	A	N	_____

Emotional Stress:	Child	Teen	Adult	None	Explain
Difficult Break-Up/Divorce	C	T	A	N	_____
High Stress Career	C	T	A	N	_____
High Family Stress	C	T	A	N	_____
Money	C	T	A	N	_____
Recurrent Physical/Mental Illness	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal/Emotional Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Body Image Issues	C	T	A	N	_____
Made Fun Of/Teased	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____
Difficulty Letting Go of Control	C	T	A	N	_____
Other	C	T	A	N	_____

Chemical Stress:	Child	Teen	Adult	None	Explain
Environment (i.e. Poor Air/Water)	C	T	A	N	_____
Smoker/Second Hand Smoke	C	T	A	N	_____
High Sugar Consumption	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Energy Drinks	C	T	A	N	_____
Vaccinations	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over the Counter Drugs (i.e. Advil, etc.)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____
Alcohol Use	C	T	A	N	_____
Antibiotics	C	T	A	N	_____
Work with Chemicals	C	T	A	N	_____
Poisoning	C	T	A	N	_____
Other	C	T	A	N	_____

Name: _____

Life Story

Family Health History

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

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 (Print) _____

Signature _____ Date ____/____/____

Name: _____

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.
- C. This 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.
- D. 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.
- E. 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.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. 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

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 and understood the 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. On occasion your insurance benefits may contribute to the cost of your care here at Healing Touch Chiropractic. Your insurance policy is between you and your insurance company, not between your insurance company and us. We are happy to provide you with a printed claim from, upon request, that you may choose to send to your insurance company. 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 ____/____/____