

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:	
Address		City	State	Zip	
Street					
Email		Home Phone:		May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Cell Phone:		May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation	Employer	Employer Phone:		May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any children? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who and where?			Date of last adjustment		
Do you have a Primary Care Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			Who & Where?	Have you seen the above provider(s) for the same reason you are seeing us today? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional <input type="checkbox"/> Cyclic					
What is the effect it has on your body functions?					
How did it start?					
Are you on any type of medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:				
Could your problem have been caused by an injury at work? <input type="checkbox"/> Yes <input type="checkbox"/> 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.					
<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	<input type="checkbox"/>	
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. You can request a copy of the Privacy Practices in its entirety at any time. 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	
<p>Please note our fees for your initial visit: Consultation, exam and nervous system scan: \$95</p> <p>X-rays, if applicable: Fee paid to radiology provider</p> <p>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.</p> <p>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.</p> <p>I, _____ have completely read and understood the above statement concerning fees and choose to receive care.</p> <p>Signature _____ Date _____</p>	

Financial Policy	
<p>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.</p> <p>*Please note that Healing Touch Chiropractic is a non-payable provider for Blue Cross Blue Shield</p> <p>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.</p> <p>I, _____ have completely read and understood the above statement concerning insurance and choose to receive care.</p> <p>Signature _____ Date _____</p>	