LIFE STORY

HEALING TOUCH CHIROPRACTIC

Vital Information

Name:_____ Date:_____

I prefer to be called:_____

Home Address:_____

City:_____ St:_____ Zip:_____

Cell Phone:_____

Email:_____

Birthday:_____ Age:_____

Occupation:_____ Employer:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed

Spouse/Partner's Name:_____

Do you have children? ☐ No ☐ Yes (How many?)_____

Names and Ages of all Children:_____

Do they have any health concerns?_____

_____

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

Have you ever been adjusted by a Chiropractor? ☐ No ☐ Yes

Who & Where?_____ Date of last adjustment:_____

Do you have a Primary Care Provider? ☐ No ☐ Yes

Who & Where?_____

Have you seen the above provider(s) for the same reason you are seeing us today? ☐ No ☐ Yes

If not, what for?_____

Additional comment (s):_____

Person to contact in case of emergency:_____

Relationship:_____ Phone Number:_____

Questions for Women

- ☐ Past pregnancy
- ☐ Currently pregnant
- ☐ Breast-feeding
- ☐ Birth control pills/patch/ring
- ☐ Painful periods
- ☐ Irregular cycles
- ☐ Fatigue
- ☐ Anxiety/Depression
- ☐ PMS
- ☐ Weight Changes

Date of last menstrual period: _____

Commitment Level

On a scale from 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 ☐

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? ☐ No ☐ Yes

How does this problem interfere at home, work, and in living a great life? _____

_____

Does handling this problem cause stress for you? ☐ No ☐ Yes

What makes it worse? _____

What makes it better? _____

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? ☐ No ☐ Yes (list:) _____

_____

Have you received an annual flu shot? ☐ No ☐ Yes

Have you received a COVID vaccine shot? ☐ No ☐ Yes (Dates of each:) _____

Do you have any relevant family health history? _____

_____

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

Have you had broken bones, surgeries, hospitalizations or car accidents? ☐No ☐Yes (explain:)_____

_____

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 fill in the stresses that you've experienced as a child, teen, and adult.

EMOTIONAL STRESS	CHILD	TEEN	ADULT	NONE	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					
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	☐	☐	☐	☐	

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 it's 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 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:

_____ _____

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:

- 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.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s).
- The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to the spine.
- 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.
- 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.
- 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.
- Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

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.

Signature: Date:

_____ _____

Our Fee Structure

Please note our fees for your initial visit:

Consultation, exam and nervous system scan: S150

Adjustments: S70

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 the Report of Findings, the time that your doctor will spend with you to go over your results, is part of the initial visit fee. Recommendations for care are based on necessity and not insurance benefits. We are a cash office and are not in network with any insurance companies.

I CLEARLY UNDERSTAND AND AGREE that I am responsible for all the bills incurred at this office relating to my care. I also understand that if I suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable.

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. 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.

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:

_____ _____