Application for Care at

RESTORE FAMILY CHIROPRACTIC

Today's Date:_____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____-_____-_____ Age: _____ Gender: _____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Marital Status:__ Single __Married __Widowed Do you have Insurance:__Yes__No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name_____Spouse's Employer: _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____
Secondary:_____Third:_____Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number:**

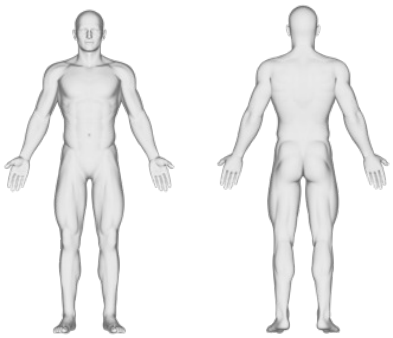
Primary or chief complaint is : 0 1 2 3 4 5 6 7 8 9 10
Second complaints is : 0 1 2 3 4 5 6 7 8 9 10
Third complaint is : 0 1 2 3 4 5 6 7 8 9 10
Fourth complaint is : 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin?_____When is the problem at its worst?__AM__PM__mid-day__late PM How long does it last?__ It is constant **OR** __I experience it on and off during the day **OR** __It comes and goes throughout the week How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? __ No __ Yes If yes, when: _____ by whom? _____

How long were you under care:_____ What were the results? _____

Name of Previous Chiropractor: _____ **__N/A**



*__PLEASE MARK__ the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

What relieves your symptoms? _____
What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:

_____
_____
_____

CURRENT ACTIVITY LEVEL:

_____
_____
_____

USUAL ACTIVITY LEVEL:

_____
_____
_____

Is your problem the result of ANY type of accident?__ Yes,__ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____
_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? __ No__Yes **If yes** how many times? _____
When was the last episode?_____How did the injury happen?_____

Other forms of treatment tried: __ No __ Yes If yes, please state what type of treatment:_____,
and who provided it:_____How long ago?_____What were the results?__Favorable
__Unfavorable Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, **C** for Currently have or **N** for Never have had:

___ Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability_____Cancer
___ Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions:

PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. Smoking: __cigars __pipe __cigarettes How often? __Daily __Weekends __Occasionally __Never
2. Alcoholic Beverage: consumption occurs __Daily __Weekends __Occasionally __Never
3. Recreational Drug use: __Daily __Weekends __Occasionally __Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? __No __Yes
If yes whom: __grandmother __grandfather __mother __father __sister(s) __brother(s) __son(s) __daughter(s)
Have they ever been treated for their condition? __No __Yes __I don't know

2. Any other hereditary conditions the doctor should be aware of? __No __Yes: _____

_____
_____
_____
_____
_____
_____
_____

I hereby authorize payment to be made directly to this office for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to this office for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed
(Type name in lieu of signature.)

_____ _____ - _____ - _____
Doctor's Name Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ HRN:_____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Concentrating	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Doing computer Work	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Gardening	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Playing Sports	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Recreation Activities	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Shoveling	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sleeping	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Watching TV	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Carrying	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Dancing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Dressing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Lifting	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Pushing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Rolling Over	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sitting	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Standing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Working	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Climbing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Doing Chores	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Driving	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Performing Sexual Activity	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Reading	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Running	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sitting to Standing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Walking	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform

Application for Care at

Please mark P for in the Past, C for Currently have and N for Never

___Headache	___Pregnant (Now)	___Dizziness	___Prostate Problems	___Heartburn
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Digestive Problems	___Digestive Problems
___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Colon Trouble	___High Blood Pressure
___Shoulder Pain	___Tremors	___Double Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Menopausal Problems	___Asthma
___Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menstrual Problem	___Difficulty Breathing
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___PMS	___Lung Problems
___Hip Pain	___Sinus/Drainage Problem	___Depression	___Bed Wetting	___Kidney Trouble
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Learning Disability	___Gall Bladder Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Eating Disorder	___Liver Trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Trouble Sleeping	___Hepatitis (A, B, C)
___Impotence/Sexual Dysfunction		___Allergies	___Ulcers	___Legs and Feet

List Prescription & Non-Prescription drugs you take:_____

_____

_____

_____

_____

How did you hear about us?

_____

_____

FOR OFFICE USE ONLY
I have reviewed the above ADL & ROS Form with the above named patient:

_____ _____
Doctor Signature Date

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at _____ have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date

(Type name in lieu of signature.)

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

__ The first day of my last menstrual cycle was on____/____/____ Date

__ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date

(Type name in lieu of signature.)

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Additional Items:

1) May we confirm your appointments by email, text or phone? ☐ Yes ☐ No
2) May we leave a message on your answering device at home or cell phone? ☐ Yes ☐ No
3) May we discuss your condition with any members of your family? ☐ Yes ☐ No
If yes, provide names: _____

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ _____
Patient Printed Name Patient Signature or legal representative
(Type name in lieu of signature.)

_____ _____
Date If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient, but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian:_____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

(Type name in lieu of signature.)

OUR OFFICE POLICIES

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Some of the care we provide occurs in an open bay area. This allows patients to observe the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

REPORT OF FINDINGS

To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

NEW INJURIES

In the event you sustain a new injury, please let the front desk coordinator know as soon as possible. There may be additional paperwork to be filled out.

RESCHEDULING APPOINTMENTS

We set up specific treatment schedules for our patients. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time. If the same day is not possible, be sure to make up the missed appointment within one week.

PROGRESS EVALUATIONS & RE-EXAMINATIONS

Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

PATIENT ACKNOWLEDGEMENT:

I have read the above Office Policies. I acknowledge receiving a copy of the Office Policies. I further acknowledge that any concerns regarding these Office Policies as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Name _____ DOB _____ HRN _____

Patient signature _____ (Type name in lieu of signature.) Date _____

Witness _____ Date _____