Acct# _______________

PATIENT DEMOGRAPHICS

Name___________________________________ Phone_______________ SSN _____________

Address_______________________________________ City________________Zip___________

Age________Birth Date____________________ Gender _________ Marital Status: S M D W

Email Address ____

Occupation_________________ Employer____________________ Phone__________________

How Many Children _________ Name of Spouse_______________________________________

Emergency Contact___________________________Phone______________________________

Referred by_____________________________________(List person's name, location, or event)

Purpose of this Appointment ____

Other Doctors seen for this condition ____

Remarks and additional information (if female, is there any possibility you may be pregnant?)____

PAYMENT IS EXPECTED AT TIME OF VISIT.

Insurance card given to the front desk? Yes No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In addition, I authorize this facility to release any information acquired in the course of my treatment to my insurance carrier(s) as necessary to process my insurance claim.

PATIENT'S SIGNATURE __________________________________ DATE__________

GUARDIAN/PARENT SIGNATURE_________________________DATE__________

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Case History

Name____ Date__________________

Have you ever received Chiropractic Care? Yes/No When?______________________________

Primary reasons for seeking chiropractic care:

Primary reason:____

Secondary reason:____

Other factors contributing to the primary and secondary reasons:____________________________

Chief Complaint: ____

Complaint started when and how? ____

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other ______________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____________

Do you have any numbness or tingling in your body? Where? ________________________________

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is the complaint present, how long does it last? ________________________________

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

Dr Notes: ____

Secondary Complaint:____

Complaint started when and how? ____

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other _____________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____________

Do you have any numbness or tingling in your body? Where? ________________________________

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10(Worst possible pain imaginable)

How frequent is the complaint present, how long does it last? ________________________________

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

Dr Notes: ____

Previous treatments, medications, surgery, or care you've sought for your complaints:

____

____

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Name_________________________________ Date_________________

<u>Circle</u> what you are currently experiencing:

Dizziness	Depression	Kidney Stones	Liver Disease	Nervousness
Headaches	Thyroid Problems	Mid Back Pain	Shoulder Pain	Epilepsy
Vertigo	Asthma	Irritable Bowel	Chronic Fatigue	Knee Pain
Ear Infection	Ulcer	Sciatica	Lupus	Infertility
Nausea	Numbness in Arms	Numbness in Legs	Fibromyalgia	Gastric Reflux
TMJ	Numbness in Hands	Numbness in Feet	Chest Pain	Neck Pain
Low Back Pain	Menstrual Disorder	Migraines	Heart Disorder	Hip Pain
ADD/ADHD	Anxiety	Stomach Disorder	Bladder Problem	Chronic Sinusitis

Other:____

Past Health Information

<u>Circle</u> any condition you have now/ have had:

Stroke	Cancer	Heart Disease	Spinal Surgery
Spinal Fracture	Seizures	Scoliosis	Diabetes

List all Surgical Operations and Years: ____
____

List ALL over the Counter & Prescription medications you are on:_________________________________
____
____

Other information : ____
____
____

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Informed Consent for Chiropractic Care

Chiropractic care, like all forms of healthcare while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a history and examination will be completed. These procedures are performed to assess your specific conditions and determine if chiropractic care is needed, or if other examinations or studies are needed. In addition they help us determine any modifications to your care or provide you with a referral to another healthcare provider.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the Doctor deems necessary and the chiropractic are, including spinal adjustments, as reported following my assessment.

Print Name: ____

Signature : ____ Date____________________________

<u>Notice of Privacy Practices Acknowledgement</u>

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment , or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature ____ Date____________________________

Release of Information

If you would like Ignite Chiropractic & Wellness to release account information to someone other than yourself, please provide the name of that person below and sign.

Person's Name ____

Patient Signature ____