

Health History Form



Name: _____ Date: _____ DOB _____ Age _____ Gender: Male/Female
 SSN#: _____ Address: _____ City, State, Zip: _____
 Cell Phone: _____ Home Phone: _____ Email address: _____
 Appointment reminders via text? YES / NO Occupation: _____ Employer's Name: _____
 Who may we thank for referring you? _____ Single/Divorced/Widowed/Married (Spouse's Name: _____)
 #of Children, Names, Ages & Gender _____

Main Health Concern History

Health Concerns: In order of Severity	Rate of Severity 1=Mild 10= Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

- Please check all that apply when describing the pain? Sharp Soreness Throbbing Tingling Dull Stiffness Spasm Burning Ache Weakness Numbness Shooting
- Does the pain travel anywhere else? YES or NO Describe: _____
- How often is this present? Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Intermittent (25% or less)
- Since it started, has the pain gotten better, worse or stayed the same? _____
- What makes your health concern worse?
 5.1. Nothing Walking Standing Sitting Exercise (moving) Lying Down Other
- Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?

- Please list all medications, including vitamins/supplements, you are taking and for what?

- Please list any broken bones, surgeries, or hospitalizations you have had and when:

- Please list any auto accidents or major slips/falls/traumas you have been involved in:

- Spinal health is especially important during pregnancy; **any chance** that you are pregnant? **YES or NO**

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 ___ Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other_____

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
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

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:

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

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

Printed Name Signature Date
Legal Guardian Signature _____ Date _____ Relationship to Minor _____

Insurance Release of Authorization/Assignment of Benefits

I hereby authorize payment to be made directly to **CTC Chiropractic** 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 **CTC Chiropractic** for any and all services I receive at this office.

Insurance Verification Form

NAME OF PRIMARY INSURANCE CARRIER: _____ NAME OF SECONDARY INSURANCE CARRIER: _____
Name of insured _____ Insured Date of Birth _____ Insured Social Security: _____

FEES: We have a zero balance policy. Payment for services is due at the time of services rendered. Payment options include; cash, check, debit/credit card, Amex, and HSA/HRA cards. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of \$15.00. We reserve the right to charge \$35 late fee for all late payments.

Patient's Signature _____ Date _____

INFORMED CONSENT

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE 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 (NECK) ADJUSTMENTS MAY BE VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE. **OUR FOCUS IN THIS OFFICE IS THE VERTEBRAL SUBLUXATION. HOWEVER, IF WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSES, OR TREATMENT FOR THOSE FINDINGS WE RECOMMEND THAT YOU SEEK ANOTHER HEALTHCARE PROVIDER. REGARDLESS OF WHAT THE DISEASE IS CALLED, WE DO NOT OFFER TO TREAT IT. NOR DO WE OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS. OUR ONLY PRACTICE OBJECTIVE IS TO LOCATE, ANALYZE AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC NEUROLOGICAL BASED CHIROPRACTIC ADJUSTMENTS.** 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.** THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISDICTION, INVOLVES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION OR REGIONS OF THE SPINE WITH THE SPECIFIC INTENT OF RE-POSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE. **YOUR COMPLIANCE WITH CARE PLANS, HOME AND SELF-CARE, ETC. IS ESSENTIAL TO MAXIMUM HEALING AND OPTIMAL HEALTH. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTORS ON ANY MATTER RELATED TO YOUR CARE AT THIS FACILITY.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). 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 understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis. I have read and fully understand the above statements.

Printed Name

Signature

Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

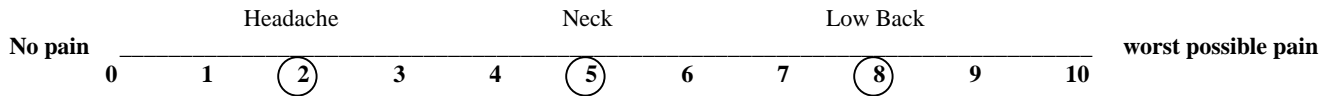
Date _____

Please read carefully:

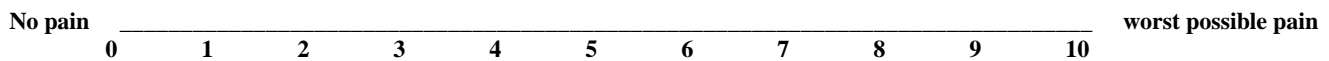
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

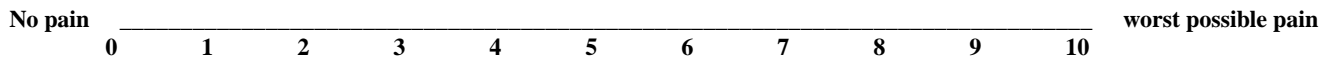
Example:



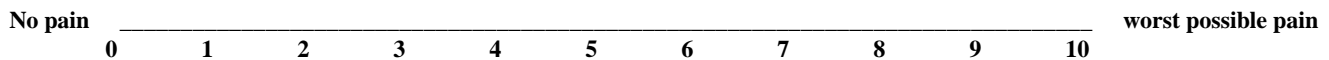
1 – What is your pain RIGHT NOW?



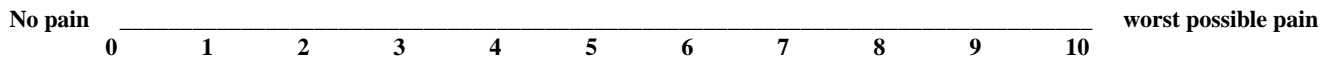
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

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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 CTC Chiropractic 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.


_____/_____/_____
Patient or Authorized Person's Signature Date  *Witness Initials*

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.

_____/_____/_____
Patient or Authorized Person's Signature Date  *Witness Initials*