Today's Date: _____

Name: _____ Age: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (  )_____ Home Phone: (  )_____ Work Phone: (  )_____

Why Chiropractic care? Chief complaint: _____ or Wellness: YES or NOT YET

Social Security #: _____ Male: _____ Female: _____

Occupation: _____ Employer: _____

Email: _____ Preferred method of contact: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

**Have you ever been adjusted by a Chiropractor? YES** or **NO** **If so, how long ago?** _____

**How were you referred to our office?** _____

# Your Health Profile

Welcome to Power Chiropractic and Wellness. Our goals are, first, to address the health concerns that brought you to this office, second, to offer you the opportunity to improve your overall health potential and well-being, and third, to answer any questions that you might have. Answering the following questions will give us a health profile allowing us to better assess your condition and help us address your current needs.

## Childhood Years

**Research is showing that many of the health challenges that we face today have their origins during our developmental years, some starting as early as birth. Please answer the following to the best of your ability.**

| | Yes | No |
|---|---|---|
| Was your birth C-section, suction or forceps? | ☐ | ☐ |
| Did you have any serious childhood illnesses? | ☐ | ☐ |
| Were you spanked or swatted as a child? | ☐ | ☐ |
| Did you experience any sports injuries as a child? | ☐ | ☐ |
| Any childhood falls or accidents? (car, crib, tree, bike, bed….) | ☐ | ☐ |
| Was there any prolonged use of medications such as antibiotics, inhalers, Ritalin? | ☐ | ☐ |
| Did you suffer any emotional trauma or significant loss as a child? | ☐ | ☐ |
| Were you checked for traumatic birth syndrome? | ☐ | ☐ |

## Adult Years

On a daily basis we experience physical trauma, chemical toxins and emotional stresses that can accumulate and result in a serious loss of our health potential. In most cases the effects are gradual, not even felt until they become serious.

| | Yes | No |
|---|---|---|
| Do / Did you smoke? | ☐ | ☐ |
| Do / Did you drink alcohol? | ☐ | ☐ |
| Have you been involved in any accidents (car, work, sports, falls)? | ☐ | ☐ |

If so, please describe (include dates): _____

_____

Do you participate in extreme sports? _____

Please list any surgery that you've had: _____

_____

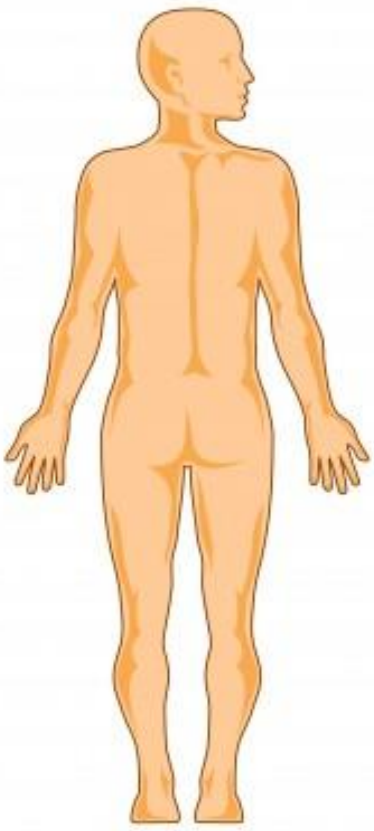
List all medications that you are taking: _____

# Chief Complaint Assessment

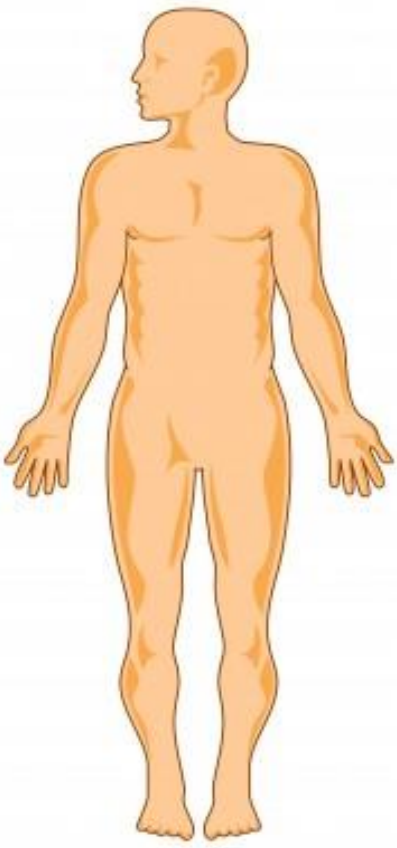
## Pain Chart

Mark the areas on the picture below that best indicates the sensations that you are experiencing. Circle the appropriate body part and use the below symbols to indicate the type of sensations.

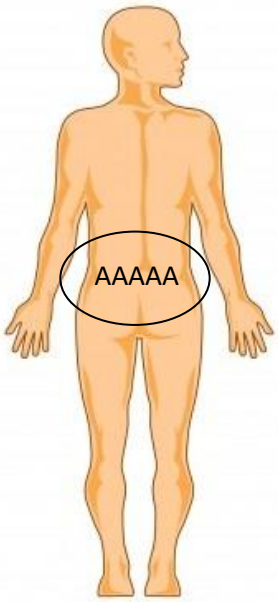
| Sharp pain | Dull Ache | Numbness | Burning | Pins and Needles | Other |
|---|---|---|---|---|---|
| PPPPPPP | AAAAAA | NNNNNN | /////// | ++++++++++++ | OOOOO |



Rear



Front




Example

Circle a number below to indicate the level of intensity of your pain or discomfort on a scale of 1-10
(1 being lowest and 10 being highest)

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neck: | No pain | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | Severe unbearable Pain |
| Mid Back: | No pain | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | Severe unbearable Pain |
| Low Back: | No pain | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | Severe unbearable Pain |
| _____: | No pain | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | Severe unbearable Pain |
| _____: | No pain | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | Severe unbearable Pain |

## Chief Complaint Assessment, Continued

On a scale of 1-10 rate your current state of health: (1=poor / 10=excellent) _____

List your chief complaints in order of severity:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Where is the pain? _____

Does the pain radiate: _____

Is your discomfort: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Comes and Goes ☐ Constant

Since your problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

Does it interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Family life

Other health care providers seen for this condition:

☐ Chiropractor:_____

☐ Medical Doctors:_____

☐ Other:_____

## Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Chiropractor, please mention their name and condition below:

Children:_____

Spouse:_____

Mother:_____

Father:_____

Brothers or sisters:_____

## Goals For My Care

What would you like to achieve through Chiropractic care? (Check one or more below)

____ **Corrective Care**: Designed to eliminate or reduce the majority of the discomfort and stabilize the condition in the shortest amount of time. During this phase of care, visits may be frequent. Repeated visits could be required to reduce or eliminate the symptoms.

____ **Comprehensive Care**: Correct any underlying spinal injury as well as strengthening the muscles, improve spinal function and provide more complete or optimum healing of tissues and organ systems. Visits occur at reducing frequency and care is supplemented by exercises and modification of your daily and work habits. **Remember, many of the conditions for which people seek chiropractic care have developed over many years and therefore, it takes time to correct these conditions.**

____ **Wellness/Maintenance Care**: Maintain your improved health and spinal function, and prevent the return of the original condition once spinal correction has been attained. **Regular attention catches small problems before they become serious. Prevention saves time and money by helping you stay well.**

____ **I don't know!**: That's okay! Please feel free to ask questions at any point throughout your consultation and moving forward. **We are here to help you in any way that we can!**

# Neurologic Scans and Systems Review

**Your central nervous system (brain and spinal cord) is the master controller of your body. It controls the function of every cell, tissue and organ. The connection between your brain and your body is through the spinal nerves: sensory, motor and autonomic nerves. Your exam may reveal interference in the autonomic nervous system. This part of your nervous system controls the functions of organs, blood vessels and glands. Please review the following systems to determine if there may be a connection between your health profile and your nerve interference.**

## SYSTEM REVIEW: Place an (x) next to the symptoms you are experiencing, or that you have experienced.

### Cervical Nerves

| | | | |
|---|---|---|---|
| ( ) eye strain | ( ) red eyes | ( ) vision problem | ( ) weight gain |
| ( ) ear infection | ( ) ringing in the ear | ( ) ear discharge | ( ) crave sweets |
| ( ) hearing loss | ( ) sinusitis | ( ) runny nose | ( ) memory loss |
| ( ) canker sores | ( ) sore throat | ( ) sore gums | ( ) nightmares |
| ( ) inner ear problems | ( ) speech difficulty | ( ) cavities | ( ) tonsillitis |
| ( ) hoarse/laryngitis | ( ) headaches | ( ) migraines | ( ) emotional instability |
| ( ) chronic fatigue | ( ) dizziness | ( ) anxiety | ( ) insomnia |

### Upper Thoracic Nerves

| | | | |
|---|---|---|---|
| ( ) asthma | ( ) chest pain | ( ) pain over heart | ( ) difficult breathing |
| ( ) persistent cough | ( ) bronchitis | ( ) coughing phlegm | ( ) coughing blood |
| ( ) rapid heartbeat | ( ) high blood pressure | ( ) heart problems | ( ) numbness in the hands/arms |
| ( ) lung problems | ( ) fluid retention | ( ) pleurisy | ( ) difficulty in swallowing |
| ( ) nausea | ( ) gall bladder attacks | ( ) bloating | ( ) intolerance to fatty foods |

### Mid Thoracic Nerves

| | | | |
|---|---|---|---|
| ( ) poor appetite | ( ) excessive hunger | ( ) gastric ulcer | ( ) crave sweets |
| ( ) difficult swallowing | ( ) excessive thirst | ( ) excessive thirst | ( ) liver trouble |
| ( ) vomiting food | ( ) abdominal pain | ( ) diarrhea | ( ) immune deficiencies |
| ( ) constipation | ( ) pancreatitis | ( ) black stool | ( ) hypoglycemia |

### Lower Thoracic Nerves

| | | | |
|---|---|---|---|
| ( ) allergies | ( ) sneezing | ( ) overwhelmed | ( ) digestive complaints after eating |
| ( ) appendix problems | ( ) bladder problems | ( ) kidney problems | ( ) testicular or ovarian problems |
| ( ) bladder infections | ( ) swollen ankles | ( ) dizziness upon standing | |

### Lumbar Nerves

| | | | |
|---|---|---|---|
| ( ) bladder trouble | ( ) IBS | ( ) bad breath | ( ) flatulence |
| ( ) bowel problems | ( ) painful urination | ( ) infertility | ( ) dark circles under eyes |
| ( ) impotence | ( ) dysmenorrhea | ( ) prostate problems | ( ) reproductive disorders |
| ( ) female problems | ( ) hemorrhoids | ( ) varicose veins | ( ) hormonal imbalances |

# ASSIGNMENT, LIEN AND AUTHORIZATION FOR

# INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health benefits coverage with the above captions, and hereby assign and convey directly to Power Chiropractic & Wellness all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature | Patient Signature | Date |
| _____ | _____ | _____ |
| Witness | Witness Signature | Date |

# Authorizations and Releases

**Patient Health Information and Privacy Policy**

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor (s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

**Consent to Professional Treatment**

The patient certifies that all information provided to this office is true and current to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

**Consent to Perform and Interpret X-rays**

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

**Assignment of Benefits and Release of Records**

The patient hereby assigns benefits to be paid directly to this provider by all the third-party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third- party payor necessary for reimbursement of charges incurred.

Initial _____

_____ _____ _____

Patient Printed Name Patient Signature Date