Confidential
Health Information

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

____
Today's Date (MM/DD/YYYY)

____
Whom may we thank for referring you?

Have you consulted a chiropractor before?
¤No ¤Yes ______________ ______________
When? **if so, whom?**

____
Your Last Name

Gender
¤Male ¤Female

____
Social Security Number

______________ ______________ ______________ ________
Your First Name **Your Middle Name (or initial)** **Birth Date** (MM/DD/YYYY) **Age**

____
Address

______________ ________ ________
City **State** **Zip/Postal Code**

Marital Status
¤Single ¤Married ¤Divorced
¤Widowed ¤Separated

____
Email Address

____
Home Phone

____
Cell Phone

____
Emergency Contact

____
Emergency Contact's Phone

____
Your Occupation

____
Your Employer

____
Address

May we contact you at work?
¤No ¤Yes

______________ ________ ________ ______________
City **State** **Zip/Postal Code** **Work Phone**

______________ ______________ ______________
Insurance Carrier **Policy Number** **Primary Care Provider's Name**

______________________ ______________________
Insured's Last Name **Insured's Social Security Number**

______________ ______________
Insured's First Name **Middle Name (or initial)**

Who carries this policy?
¤Self ¤Spouse ¤Parent

______________ ______________ ______________
Insured's Phone Number **Birth Day** (MM/DD/YYYY) **Insured's Employer**

____
Insured's Address

______________ ________ ________ ______________
City **State** **Zip/Postal Code** **Employer's Phone**

1. The symptom(s) that have prompted me to seek care today include: ___________________________________

____

2. And are the result of (check box) ▫An accident or injury
▫Work ▫Auto ▫Other ____
▫A worsening long-term problem _____________________________________
▫An interest in: ▫Wellness ▫Other__________________________________

3. Onset (When did you first notice your current symptoms?)

____

4. Intensity (How extreme are your current symptoms?)

0 ◯◯◯◯◯◯◯◯◯◯◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel symptoms?)

◯◯◯◯◯◯◯◯◯◯◯
0% 50% 100%

6. Quality of symptoms (What does it feel like?)

▫Numbness
▫Tingling
▫Stiffness
▫Dull
▫Aching
▫Cramps
▫Nagging
▫Sharp
▫Burning
▫Shooting
▫Throbbing
▫Stabbing
▫Other______________________

7. Location (where does it hurt?) Circle the areas(s) on the illustration. "O" for current conditions experienced in the past?

8. Radiation (does it affect other areas of your body? To what areas does it travel?) _________________________________

9. Aggravating or relieving factors. (What makes it better or worse?)
What tends to **worsen** the problem?____

What tends to **lessen** the problem?____

10. Prior Interventions(what have you done to relieve the symptoms?)
▫Prescription Medication ▫Surgery ▫Ice ▫Over-the-counter drugs ▫Acupuncture ▫Heat ▫Homeopathic remedies
▫Chiropractic ▫Physical Therapy ▫Massage Other____

11. What else should we know about your current condition? ____

12. How does your current condition interfere with your:

Work or career:____

Household responsibilities:____

13. Have you had any diagnostic Imaging done? (circle one) X-rays / MRI / CT / Other ______________________

If so, When and Where? ____

Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the square beside any condition that you have Had or currently Have and initial to the right.

a. Musculoskeletal

▫None

▫Osteoporosis ▫Arthritis ▫Scoliosis ▫Neck Pain Initials___

▫Knee Injuries ▫Foot/Ankle pain ▫Shoulder Problems ▫Elbow/Wrist pain

▫TMJ issues ▫Hip Disorders ▫Poor Posture ▫Back Problems

b. Neurological

▫None

▫Anxiety ▫Depression ▫Headache ▫Dizziness Initials___

▫Pins & Needles ▫Numbness

c. Cardiovascular

▫None

▫High blood pressure ▫Low blood pressure ▫High Cholesterol ▫Poor Circulation Initials___

▫Angina (chest pain) ▫Excessive bruising

d. Respiratory

▫None

▫Asthma ▫Apnea (difficulty breathing) ▫Emphysema ▫Hay fever Initials___

▫Pneumonia ▫Shortness of breath

e. Digestive

▫None

▫Anorexia/Bulimia ▫Ulcer ▫Food sensitivities ▫Heartburn ▫Constipation ▫Diarrhea Initials___

f. Sensory

▫None

▫Blurred Vision ▫Ringing in ears ▫Hearing loss ▫Chronic ear infection ▫Loss of smell Initials___

▫Loss of taste

g. Integumentary

▫None

▫Skin Cancer ▫Psoriasis ▫Eczema ▫Acne ▫Hair loss ▫Rash Initials___

h. Endocrine

▫None

▫Thyroid issues ▫Immune disorders ▫Hypoglycemia ▫Frequent infection ▫Swollen glands Initials___

▫ Low Energy

i. Genitourinary

▫None

▫Kidney Stones ▫Infertility ▫Bedwetting ▫Prostate issues ▫Erectile dysfunction Initials___

▫PMS symptoms ▫Kidney Infection ▫Urinary Tract Infection

j. Constitutional

▫None

▫Fainting ▫Weakness ▫Low libido ▫Poor appetite ▫Fatigue Initials___

▫Sudden weight loss/gain

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illness that you have Had in the past or Have now. (Please check all that apply)

- ▫AIDS
- ▫Alcoholism
- ▫Allergies
- ▫Arteriosclerosis
- ▫Cancer
- ▫Chickenpox
- ▫Diabetes
- ▫Epilepsy
- ▫Glaucoma
- ▫Goiter
- ▫Gout
- ▫Heart Disease
- ▫Hepatitis
- ▫Malaria
- ▫Measles
- ▫Multiple Sclerosis
- ▫Mumps
- ▫Polio
- ▫Rheumatic fever
- ▫Scarlet fever
- ▫Sexually Transmitted Disease
- ▫Stroke
- ▫Tuberculosis
- ▫Typhoid fever
- ▫Ulcer
- ▫Other

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ▫Appendix removal
- ▫Gallbladder
- ▫Cancer
- ▫Cosmetic Surgery
- ▫Gastric Bypass Surgery
- ▫Lap Band Surgery
- ▫Sleeve Gastrectomy
- ▫Heart Bypass Surgery
- ▫Pacemaker
- ▫Hysterectomy(Full/Partial)
- ▫Eye surgery
- ▫Spine _____________

____
____

- ▫Adenoidectomy
- ▫Tonsillectomy
- ▫Vasectomy
- ▫ Mastectomy
- ▫Other _____________

____
____
____
____

16. Treatments

Check the ones you've received in the Past or are receiving Currently.

- ▫Acupuncture
- ▫Antibiotics
- ▫Birth Control
- ▫Blood transfusion
- ▫Chemotherapy
- ▫Chiropractic care
- ▫Dialysis
- ▫Herbs
- ▫Homeopathy
- ▫Hormone replacement
- ▫Inhaler
- ▫Massage therapy
- ▫Physical therapy
- ▫Nutritional supplements

List: ________________________
____
____

▫Medications (Rx & OTC)

____
____
____
____
____

17. Injuries- Have you ever...

- ▫Had a fracture or broken bone
- ▫Used crutches or other support
- ▫Had a spine or nerve disorder
- ▫Used neck or back bracing
- ▫Been knocked unconscious
- ▫Received a tattoo; number______ location(s)__________________________
- ▫Been injured in an accident
- ▫Had a body piercing; number______ location(s)________________________

18. Allergies

Are you allergic to any medications? ▫**Yes** ▫**No**

If Yes, please list:____

Family History

Some health issues are hereditary. Tell us about the health of your family members.

Relative	Age (if living)	State of Health Good	State of Health Poor	Illnesses	Age at death	Cause of Death Natural	Cause of Death Illness
Mother	__________	▫	▫	_____________________	__________	▫	▫
Father	__________	▫	▫	_____________________	__________	▫	▫
Sister 1	__________	▫	▫	_____________________	__________	▫	▫
Sister 2	__________	▫	▫	_____________________	__________	▫	▫
Brother 1	__________	▫	▫	_____________________	__________	▫	▫
Brother 2	__________	▫	▫	_____________________	__________	▫	▫

Are there any other hereditary health issues you know about? (Grandparents,etc.) ___________________________

Social History
Tell us your health habits and stress levels.

Alcohol use ▫Daily ▫Weekly How much?________________ Prayer or meditation? Yes▫ No▫
Coffee use ▫Daily ▫Weekly How much?________________ Job pressure/stress? Yes▫ No▫
Tobacco use ▫Daily ▫Weekly How much?________________ Financial peace? Yes▫ No▫
Exercising ▫Daily ▫Weekly How much?________________ Mercury fillings? Yes▫ No▫
Pain relievers ▫Daily ▫Weekly How much?________________ Recreational drugs? Yes▫ No▫
Soft drinks ▫Daily ▫Weekly How much?________________ Vaccinated? Yes▫ No▫
Water intake ▫Daily ▫Weekly How much?________________
Hobbies ____

Activities of Daily Living
How does this condition currently interfere with your life and ability to function? (For each activity, circle the number that most closely describes your condition right now)

	No Affect	**Mild Affect**	**Moderate Affect**	**Severe Affect**	**Worst Pain**
Sitting	0	1	2	3	4
Standing	0	1	2	3	4
Sleeping	0	1	2	3	4
Rising out of a chair	0	1	2	3	4
Bending over	0	1	2	3	4
Personal Care (washing, dressing, etc.)	0	1	2	3	4
Lifting Objects	0	1	2	3	4
Travel (driving, looking over shoulder, etc.)	0	1	2	3	4
Walking	0	1	2	3	4
Work	0	1	2	3	4

Score_______________

19. What is the major stressor in your life? ____

20. How much do you sleep on average per night? _________Hours

21. What is the type and approximate age of your mattress?_____________________ Pillow?__________________

22. What is your preferred sleeping position? ____

23. Describe your typical eating habits ▫Skip breakfast ▫2 meals/day ▫3 meals/day ▫Snack between meals

24. What would be the most significant thing you could do to improve your health?_____________________________

25. In addition to the main reason for your visit today, what additional health goals do you have?_________________

____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each of the statements and initial your agreement to the following:

Initials _____ I instruct the doctor to deliver care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ In the event that may warrant the need to take radiographs, I realize that an x-ray examination may be hazardous to an unborn child and I certify to the best of my knowledge I am not pregnant. If I am or do become pregnant I will notify the doctor immediately.
Date of last menstrual period._____________________

Initials _____ I grant the permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials _____ I acknowledge that arriving 10 or more minutes late to my scheduled appointment time will be considered a no-show, and I may be charged with a $25 service fee. I understand that I may be rescheduled due to my tardiness. The office can determine if you may still be seen, depending on appointment availability. Please understand the Doctor runs on a very tight schedule in order to see all her scheduled patients.

If the patient is a minor child, print the child's full name: ____

____ _____________________________
Signature **Date** (MM/DD/YYYY)

Financial Policy

At Heartland Chiropractic & Wellness, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy, a member of our staff will be glad to assist you.

Health Insurance

- As a courtesy to you, when given a copy of your insurance card, we will call and verify your benefits for chiropractic care in our office.
- We do Not file claims for acupuncture, massage, lab work, orthotics, supplements or merchandise to your insurance.
- If you receive care that we do not file for, you will need to pay for the services rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make a copy of your fee slip. Please remember- the benefits information your insurance company quotes us is not a guarantee of payment from them and any remaining fees are due immediately from you.

Medicare

- Medicare covers spinal adjustments only. After your yearly deductible has been met, Medicare should cover 80% of the allowed costs for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services.
- You will be asked to fill out and sign an Advanced Beneficiary Notice (ABN) for non-covered services.

Secondary Insurance

- Please inform us of any secondary insurance you may have. We will be glad to file chiropractic claims to your secondary insurance after your primary insurance has processed the claim(s).

Auto Accidents

- If you've not already done so, please notify your auto insurance carrier of your accident immediately. We will have fill out the proper document so we can file claims with your insurance carrier. We will call your adjuster to gather the information we need to file.
- If you reach the maximum amount payable under your auto insurance, we will file the claim through your health insurance. Although you are ultimately responsible for your Bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you spend/terminate care against physician’s recommendations, any remaining fees are due from you.
- If there is a third party involved (such as an attorney), you'll be asked to make partial payments as care is received. Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's now ledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

Patients Without Insurance

- We request that 100% of all visits be paid in full at the time of service.
- We gladly accept cash, checks, credit/debit cards, HSA, and flex-pay cards.

Changes to any appointment should be made 24 hours in advance to avoid a $25 service fee. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any acceptable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all changes related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our financial policy. Please let us know if you have any questions.

I have read, understand and agree to this Financial Policy in its entirety.

____
Printed Name

____ ______________________
Signature Date

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in the office. With consent from you, it is the policy of this office to use your PHI in the following manners:

1. Treatment: your PHI will be given to these professionals that require it to provide care.
2. Appointment reminders: our staff may call from time to time to remind you of appointments
3. Sign-in log: We maintain a log of incoming patients for our own statistical use
4. Medical doctors: it is the policy of this office to share our findings with your regular medical doctor. This helps us build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

1. Personal representative: in accordance with applicable law that may represent you
2. Emergency situations
3. Abuse, neglect, and domestic violence
4. Law enforcement issues
5. Worker's Compensation claims
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request.
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time
5. Complain to the practice

Printed Name: ____

Signature: ____ Date: ________________________

CONSENT TO TREAT

The primary treatment used by the doctor of chiropractic is the spinal adjustment.
We will use that procedure to treat you.

The nature of the chiropractic adjustment.
We will use hands or a mechanical device upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. This audible is formally known as a "cavitation", which is simply a gas release from your joints. You may feel or sense movement in the joint(s) adjusted.

The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations and muscle strain, and costovertebral strain and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious, but rare complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority, saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

The availability and nature of other treatment options.
Other treatment options for your condition include:
- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Surgery

Note: There are risks and side effects that occur with these other treatment options.

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Do Not Sign Until You Have Read and Understand the Above.

Please Check the Appropriate Block and Sign Below:

I have read ▫ or have had read to me ▫ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Date:____________________________

____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

____
Authorized Doctor Signature