ABOVE ALL
CHIROPRACTIC CENTER

Name: _____ Date: _____/_____/_____

Current Health Information

List your health concerns below:

	Health Concerns: (List according to severity)	Rate of Severity 1 = Mild 10 = Unbearable	When did the Symptoms Start?	Are the Symptoms Constant or Intermittent?	If you are experiencing pain is it: Shooting, Radiating, Cramping, Throbbing, Sharp, Dull, Burning
1					
2					
3					
4					
5					

Is your health concern related to an **auto accident**? YES/NO

Please describe how your health concerns are affecting your life:_____

_____

Since your problem started, is it: THE SAME GETTING BETTER GETTING WORSE

Does the pain radiate to any other body parts?_____

Do you notice the symptoms during a certain time of the day?_____

What makes it Better?_____

What makes it Worse?_____

Have you ever seen another Doctor for these Conditions? YES / NO

Chiropractor? YES / NO Medical Doctor? YES / NO Other?_____

Who & When?_____

Continued On Back

Circle 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	Trouble Sleeping	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:_____

Pregnant: YES/NO If yes, how far along _____

Past Health Information

Circle 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: _____

_____

When was your last Auto Accident? _____

Have you ever had previous Chiropractic Care? YES NO

If so, by whom and when? _____

Have you ever been knocked Unconscious? YES NO Fractured a Bone? YES NO

If yes, Please Describe:_____

Other Trauma: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

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 A 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 HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

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 CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

Print Name Here

_____ Date _____

Signature

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. 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.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. 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 doctors of chiropractic in the United States alone.

Continued On Back

D. A thorough chiropractic examination and evaluation is part of the standard

chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, Its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

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 (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 PRATICES 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 used to disclose 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.

_____ _____

Signature Date

If Practice Member is a Minor/Child, a Parent or Guardian Must Sign Below

_____ _____

Signature of Guardian Date

_____

Relationship to Minor/Child

_____ _____

Witness Signature (Office Staff) Date

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF ABOVE ALL CHIROPRACTIC CENTER DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

PRINTED NAME _____ DATE _____

SIGNATURE _____ YOUR AGE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT ABOVE ALL CHIROPRACTIC CENTER.

SIGNATURE _____ DATE _____

Name:						
MR #						
Date:						
	A-P C	A-P T	A-P LP	Lat C	Lat T	Lat L
cm						

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE