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.					

1. Please check all that apply when describing the pain? ___Sharp ___Soreness ___Throbbing ___Tingling ___Dull ___Stiffness ___Spasm ___Burning ___Ache ___Weakness ___Numbness ___Shooting

2. Does the pain travel anywhere else? ___Yes ___No Describe:_____

3. How often is this present? ___Constant (81-100%) ___Frequent (51-80%) ___Occasional (26-50%) ___Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse, or stayed the same?_____

5. What makes your health concern worse? ___Nothing ___Walking ___Standing ___Sitting ___Exercise(moving)___Lying down ___Other

6. Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?

   _____

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

   _____

   _____

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

   _____

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

_____

_____

10. 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, what type of treatment? _____
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 ___Cerebral Vascular ___Other_____

SOCIAL HISTORY

1. Smoking: ___Cigars ___Pipe ___Cigarettes How often? __Daily __Weekends __Occasionally __Never
2. Alcoholic Beverages: consumption occurs __Daily __Weekends __Occasionally __Never
3. Recreational Drug use: __Daily __Weekends __Occasionally __Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same conditions? __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? ___Yes ___No ___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 Quest for Health 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 Quest for Health Chiropractic for any and all services that 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, and HAS/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 a $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 INCLUDE:SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTNACE PER ONE MISSION TO ONE PER TWO MILLION CERBICAL 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 OCERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIOPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATION 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 ENCOUTER NON-CHIROPRACTIC OR UNUSUAL FINIDNGS 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 OFFCER ADVICE REGARDING**

TREATMENT PRESCRIBED BY OTHERS. OUR ONLY PRACTICE OBJECTIVE IS TO LOCATE, ANAYLZE, AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC, NEUROLOGICALLY BASED CHIROPRACTIC ADJUSTMENTS. CHIROPRACTIC IS A VERY SPECIFIC SCIENCE, AUTHORIZED BUY 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 CHIRPRACTIC 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 MATTTER RELATED TO YOUR CARE AT THIS FACILITY.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDMENT

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 that you are not required to agree to my requested restrictions, but if you agree, they you are bound to abide by such restrictions.

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

_____	_____	_____
Printed Name	Signature	Date

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