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# CONFIDENTIAL
# HEALTH INFORMIATION

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)

_____ Patient Number (office use only)

Have you consulted a chiropractor before?

_____ How did you hear about us?

O No O Yes When? _____ If so, whom? _____

_____ Your Last Name

_____ Your Social Security Number

_____ Birth Date (MM/DD/YYYY)

_____ Age

_____ Your First Name

_____ Your Middle Name (or initial)

Gender
O Male O Female

_____ Address

Marital Status O Married
O Single O Divorced
O Widowed O Separated

_____ City

_____ State/Province

_____ Zip/Postal Code

_____ Home Phone

_____ Cell Phone

_____ Spouse's Name

_____ Email Address

_____ Child's Name and Age

_____ Emergency Contact

_____ Emergency Contact's Phone

_____ Child's Name and Age

_____ Your Occupation

_____ Child's Name and Age

_____ Your Employer

_____ Work Phone

_____ Address

May we contact you at work?
O Yes O No

_____ City

_____ State/Province

_____ Zip/Postal Code

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email

_____ Primary Care Provider's Name

_____ Insurance Carrier (AUTO ACCIDENT/WORKMANS COMP ONLY)

_____ Policy Number

_____ Insured's Last Name

_____ Birth Date (MM/DD/YYYY)

Who carries this policy?
O Self O Spouse O Parent

_____ Insured's First Name

_____ Insured's Middle Name (or initial)

_____ Insured's Employer

_____ Address

_____ City

_____ State/Province

_____ 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 (darken circle):** O An accident or injury
O Work O Auto O Other _____
O A worsening long-term problem
O An interest in: O Wellness O Other_____

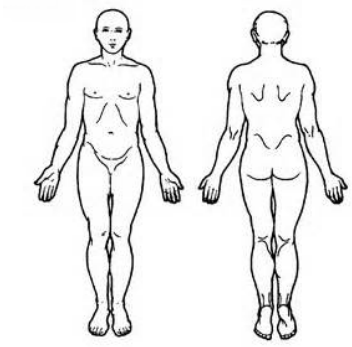
3. **Onset** (When did you first notice Your current symptoms?)
_____

4. **Intensity** (How extreme are your current systems?)
0- O-O-O-O-O-O-O-O-O-O-10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
O Constant O Comes and goes. How Often?_____
_____

6. **Quality of symptoms** (What does it feel like?)
O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramps
O Nagging
O Sharp
O Burning
O Shooting
O Throbbing
O Stabbing
O Other _____

7. **Location**(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of the day, movements, certain activities, etc.)
What tends to worsen the problem?_____
What tends to lessen the problem?_____

10. **Prior Interventions** (What have you done to relieve the symptoms?)
O Prescription medication O Surgery O Ice
O Over-the-counter drugs O Acupuncture O Heat
O Homeopathic Remedies O Chiropractic O Other_____
O Physical Therapy O Massage _____

11. **What else should Elevate Sport & Spine know about your current condition?**
_____
_____

12. **How does your current condition interfere with your**:

**Work or career**:_____
**Recreational activities**:_____
**Household responsibilities**:_____
**Personal relationships**:_____

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle besides any condition that you've **Had** or currently **Have**.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Osteoporosis | O | O | Arthritis | O | O | Scollosis | O | O | Neck pain | O | O | Back problems | O | O | Hip disorder | |
| O | O | Knee Injuries | O | O | Foot/Ankle pain | O | O | Shoulder problems | O | O | Elbow/wrist pain | O | O | TMJ Issues | O | O | Poor posture | |

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Anxiety | O | O | Depression | O | O | Headache | O | O | Dizziness | O | O | Pins & Needles | O | O | Numbness | |

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | High Blood pressure | O | O | Low Blood pressure | O | O | High cholesterol | O | O | Poor Circulation | O | O | Angina | O | O | Excessive bruising | |

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Asthma | O | O | Apnea | O | O | Emphysema | O | O | Hay fever | O | O | Shortness of breath | O | O | Pneumonia | |

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Anorexia/ bulimia | O | O | Ulcer | O | O | Food sensitivities | O | O | Heartburn | O | O | Constipation | O | O | Diarrhea | |

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Blurred vision | O | O | Ringing in ears | O | O | Hearing loss | O | O | Chronic ear infection | O | O | Loss of smell | O | O | Loss of taste | |

**g. Skin**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Skin cancer | O | O | Psoriasis | O | O | Eczema | O | O | Acne | O | O | Hair Loss | O | O | Rash | |

_____
**Patient Name**

_____
**Patient Number**
(office use only)

_____
**Doctor's Initials**

*(Continued from previous page)*

**h. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Thyroid issues | O | O | Immune disorders | O | O | Hypoglycemia | O | O | Frequent infection | O | O | Swollen glands | O | O | Low energy | initials____ |

**i. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Kidney stones | O | O | Infertility | O | O | Bedwetting | O | O | Prostate issues | O | O | Erectile dysfunction | O | O | PMS symptoms | initials_____ |

**j. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| O | O | Fainting | O | O | Low libido | O | O | Poor appetite | O | O | Fatigue | O | O | Sudden weight Gain/loss (circle one) | O | O | Weakness | initials_____ |

## Past Personal, Family and Social History

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

### PERSONAL

**14. Illnesses**

Check the Illnesses you have Had in the past or Have now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| O | O | AIDS | O | O | Tuberculosis |
| O | O | Alcoholism | O | O | Typhoid fever |
| O | O | Allergies | O | O | Ulcer |
| O | O | Arteriosclerosis | O | O | Other:_____ |
| O | O | Cancer | | | _____ |
| O | O | Chicken pox | | | _____ |
| O | O | Diabetes | | | _____ |
| O | O | Epilepsy | | | _____ |
| O | O | Glaucoma | | | _____ |
| O | O | Goiter | | | _____ |
| O | O | Gout | | | _____ |
| O | O | Heart disease | | | _____ |
| O | O | Hepatitis | | | |
| O | O | HIV positive | | | |
| O | O | Malaria | | | |
| O | O | Measles | | | |
| O | O | Multiple Sclerosis | | | |
| O | O | Mumps | | | |
| O | O | Polio | | | |
| O | O | Rheumatic fever | | | |
| O | O | Scarlet fever | | | |
| O | O | Sexually transmitted Disease | | | |
| O | O | Stroke | | | |

**15. Operations**

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

- **O** Appendix removal
- **O** Bypass surgery
- **O** Cancer
- **O** Cosmetic surgery
- **O** Elective surgery:_____ _____
- **O** Eye surgery
- **O** Hysterectomy
- **O** Pacemaker
- **O** Spine _____ _____:_____ _____
- **O** Tonsillectomy
- **O** Vasectomy
- **O** Other:_____ _____ _____ _____

**16. Treatments**

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

| Past | Currently | |
|---|---|---|
| O | O | Acupuncture |
| O | O | Antibiotics |
| O | O | Birth control pills |
| O | O | Blood transfusions |
| O | O | Chemotherapy |
| O | O | Chiropractic care |
| O | O | Dialysis |
| O | O | Herbs |
| O | O | Homeopathy |
| O | O | Hormone Replacement |
| O | O | Inhaler |
| O | O | Massage therapy |
| O | O | Nutritional supplements |

**List:**_____ _____ _____ _____

O O Medications (prescriptions and over-the-counter):
_____ _____ _____

**17. Injuries**

Have you ever…

- **O** Had a fractured or broken bone
- **O** Had a spine or nerve disorder
- **O** Had been knocked unconscious
- **O** Been injured in an accident
- **O** Used a crutch or other support
- **O** Used neck or back bracing
- **O** Received a tattoo
- **O** Had a body piercing

### FAMILY

**18. Family History**

Some health issues are hereditary. Tell Elevate Sport & Spine about the health of your immediate family members

| Relative | Age (If living) | State of health Good | Poor | Illnesses. | Age at death | Cause of death Natural | Illness |
|---|---|---|---|---|---|---|---|
| **Mother** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |
| **Father** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |
| **Sister 1** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |
| **Sister 2** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |
| **Brother 1** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |
| **Brother 2** | _____ | **O** | **O** | _____ | _____ | **O** | **O** |

**19. Are there any other hereditary health issues that you know about?**_____
_____

### SOCIAL

**20. Social History**

Tell Elevate Sport & Spine about your health habits and stress levels.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Alcohol use** | **O Daily** | **O Weekly** | **How Much?** _____ | **Prayer or meditation?** | **O Yes** | **O No** |
| **Coffee use** | **O Daily** | **O Weekly** | **How Much?** _____ | **Job pressure/stress?** | **O Yes** | **O No** |
| **Tobacco use** | **O Daily** | **O Weekly** | **How Much?** _____ | **Financial peace?** | **O Yes** | **O No** |
| **Exercising** | **O Daily** | **O Weekly** | **How Much?** _____ | **Vaccinated?** | **O Yes** | **O No** |
| **Pain Relievers** | **O Daily** | **O Weekly** | **How Much?** _____ | **Mercury fillings?** | **O Yes** | **O No** |
| **Soft Drinks** | **O Daily** | **O Weekly** | **How Much?** _____ | **Recreational drugs?** | **O Yes** | **O No** |
| **Water Intake** | **O Daily** | **O Weekly** | **How Much?** _____ | | | |

**Hobbies** _____

_____
**Patient Name**

_____
**Patient Number**
(office use only)

_____
**Doctor's Initials**

**21. Activities of Daily Living**

How does this condition currently interfere with your life and abilities to function?

| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|---|---|---|---|---|
| Sitting | O | O | O | O | Grocery Shopping | O | O | O | O |
| Rising out of chair | O | O | O | O | Household chores | O | O | O | O |
| Standing | O | O | O | O | Lifting objects | O | O | O | O |
| Walking | O | O | O | O | Reaching Overhead | O | O | O | O |
| Laying down | O | O | O | O | Showering or bathing | O | O | O | O |
| Bending over | O | O | O | O | Dressing myself | O | O | O | O |
| Climbing stairs | O | O | O | O | Love Life | O | O | O | O |
| Using a computer | O | O | O | O | Getting to sleep | O | O | O | O |
| Getting in/out of car | O | O | O | O | Staying asleep | O | O | O | O |
| Driving a car | O | O | O | O | Concentrating | O | O | O | O |
| Looking over shoulder | O | O | O | O | Exercising | O | O | O | O |
| Caring for family | O | O | O | O | Yard work | O | O | O | O |

**22. What is the major stressor in your life?_____** **23. How much sleep do you average per night?_____hours**

**24. What is the type and approximate age of your mattress and pillow?_____** **25. What is your preferred sleeping position_____**

**26. Describe your typical eating habits:** **O** Skip breakfast **O** Two meals a day **O** Three meals a day **O** Snacking between meals

**27. What would be the most significant thing that you could do to improve your health?_____**

_____

**28. In addition to the main reason for our 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 statement and Initial your agreement.

I instruct the chiropractor to deliver the care that, in his or 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 m behalf for seeking reimbursement from any involved third parties.

Initials_____

I realize that and X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY)_____

Initials_____

I grant permission to be called to confirm or reschedule an appointment between the carrier and me 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_____

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

Signature_____ _____

Date (MM/DD/YYYY)

_____

**Patient Name**

_____

**Patient Number**
(office use only)

_____

**Doctor's Initials**

ELEVATE
SPORT & SPINE CENTER

# Informed Consent to Chiropractic Treatment

All physicians are required by law to obtain your informed consent prior to starting treatment. I,_____do herby give my consent to the performance of conservative, noninvasive treatment to the joints and tissues of the body. I understand that these procedures may consist of manipulations and adjustments involving the movement joints and soft tissues. Physical therapy, rehabilitative exercises, passive care modalities, and other procedures may be used.

Chiropractic care commonly involves the doctor using his/her hands or a mechanical device in order to mobilize the joints and soft tissues of the body. You may feel a "click" or "pop," much like when a knuckle is "cracked," and you may feel movement of the joint.

Although osseous manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- Soreness: I am aware that it is common to experience muscle soreness following treatment. I am also aware that complications such as bruising, redness, and swelling are possible side effects of particular treatments.

- Dizziness: Temporary symptoms such as dizziness and nausea can occur but are extremely rare

- Fractures/Joint Injury: I understand that in isolated cases with underlying physical defects, deformities, or pathologies such as weakened bone structure due to osteoporosis may render the patient susceptible to injury. When these or other pathologies are detected, the physicians will proceed with extra caution.

- Stroke: The risk of stroke due to chiropractic manipulation is extremely rare. The risk of complications such as stroke due to chiropractic treatment has been estimated at one in one million to one in twenty million, and can be further reduced by taking extra precautions during screening measures during our physical exam. These tests will be performed on each patient to minimize the risk of any complication from treatment and the patient freely assumes these risks.

**Alternative Treatments Available**

Reasonable alternatives to these procedures have been explained to me, including:

- Medications (both over the counter and prescription): Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication can actually mask pathology, produce inadequate or short term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Medications can also involve serious health risks, including irritation to the stomach lining and liver and kidneys.

- Rest/Exercise: It has been explained that rest is always an option, as it may temporarily reduce pain and inflammation, however typically this is not likely to completely reverse pathology. The same is true for use of ice, heat, or other home therapies. Prolonged sedentary lifestyles contribute to weakened bones, muscle tightness, and joint stiffness. Exercises that are appropriate for my condition and executed properly can enhance healing, however it is in my best interest to be guided through appropriate rehab by my chiropractic physician in order to reduce the risk of further injury.

- Hospitalization/Surgery: In conjunction with medical care can add to risk of exposure of virulent communicable disease in a significant number of cases. While in some cases is necessary, I understand the risks involved with consenting to an invasive form of therapy without first seeking conservative management.

- Non-treatment: I understand the potential risks of refusing or neglecting care may include the formation of adhesions, scare tissue, increased pain, restricted motion, possible nerve damage, increased inflammation and degenerative changes, and an overall worsening of pathology. The aforementioned may complicate later treatments, making future recovery and rehabilitation more difficult and lengthier.

**I have read or have had read to me the above explanation of chiropractic treatment. I have had any further unique and unusual risks of my individual condition explained to me. I have had the opportunity to have any questions or concerns answered and addressed to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely and voluntarily made my decision to undergo any recommended treatment, and hereby give my full consent to treatment.**

I attest to my consent to these procedures; I hereby affix my signature to this authorization for treatment.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature | Date |
| _____ | _____ | |
| Relationship to Patient | Witness Signature | |

ELEVATE
SPORT & SPINE CENTER

# Payment Policy

There are two acceptable forms of payment upon completion of services:

**CASH**

OR

**Credit Card/Check**

## Payment Assignment

It is our desire to assist our patients whenever possible. The following payment assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. If you discontinue your care for any reason, you will be responsible for any unpaid balance remaining.
2. Any bank fee incurred from returned or bounced personal checks will be the patient's responsibility. We reserve the right to add an additional fee of $50 for any returned or bounced checks.
3. You agree to pay the clinic fees at the time of service. If payment is not made, we reserve the right to discontinue care until payment is made or to seek outside counsel to obtain payment.
4. The clinic fees are as structed below and are subject to change. If the clinic fees change, we will provide written notice in the office and other outlets to let patients know at least 3 months before the change takes effect.
5. Clinic fees examples: New patient examination and treatment $150. Subsequent follow up visit(s) $65, New Injury unrelated to previous care which includes examination and treatment $100. Re-evaluation visit is considered when a patient has been not seen in our office within 3 months. This includes the same protocol as a new patient which includes examination and treatment, $100. Express adjustment is just an adjustment only, $50. These values mentioned above are subject to change and are for demonstrational purposes to show how our fee schedule is structured.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Social Security # | Date |

# Acknowledgement of Receipt of Notice of Privacy Practices

***This form will be retained in your medical record.***

## NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:**_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Elevate Sport and Spine Center**

I understand that the Notice describes the uses and disclosures of my protected health information by **Elevate Sport and Spine Center** and informs me of my rights with respect to my protected health information. **Elevate Sport and Spine Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice upon request.

*Patient's Signature or that of Legal Representative*

*Printed Name of Patient or that of Legal Representative*

*Today's Date*

*If Legal Representative, Indicate Relationship*

## FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

*Employee Name*

*Today's Date*