

Confidential Patient Health Record

Date: ___/___/___

Circle One: Divorced Married Single Separated Widowed

Birth Date: ___/___/___ Age: _____ Gender: Male/ Female

First: _____ Middle: _____ Last: _____

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

Home Phone: _____ Cell Phone: _____

Social Security#: ____ - ____ - ____ Email Address: _____

Spouses Name: _____ Children (Ages): _____

How did you hear about us?

Employer

Business Name: _____ Occupation/Job Title: _____

Business Phone: _____ Business Fax: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who is Responsible for Your Bill?

- Self Insurance Medicare Other (be specific)

Insurance: _____ Insured person's name: _____

Ins. Person's Soc. Sec. #: _____ Ins. Person's Date of Birth: _____

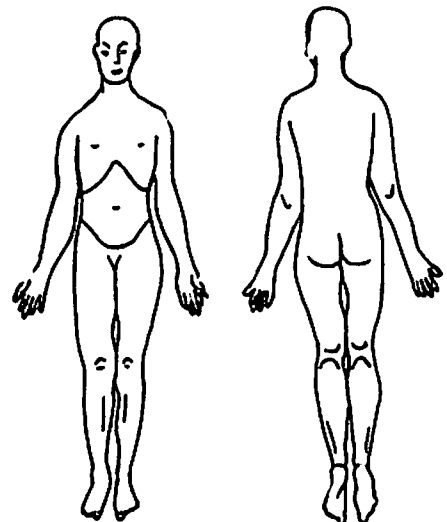
Subscriber ID: _____ Group #: _____

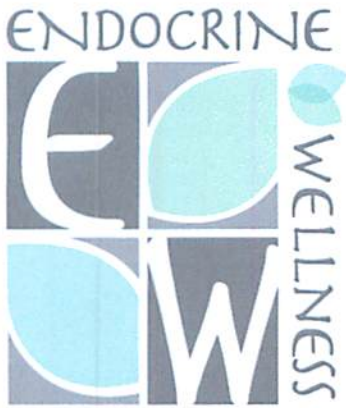
Contact Persons Name: _____ Phone Number: _____

Are you experiencing any pain or adverse sensations?

On the diagram to the right, use the letters below to indicate the type and location of any sensations you are feeling right now:

| | | |
|---------------------|----------------------------|---------------------|
| A = Ache | B = Burning | N = Numbness |
| S = Stabbing | P =Pins and Needles | O =Other |





Youth Health History Questionnaire
(To be completed by patient's parent)

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: M / F (circle one)
Weight: _____ Height: _____

Chief Complaint(s) / Reason for this visit: _____

Prescription Drug Usage - Is your child presently receiving any medications? YES NO

Please list the exact names of any medications your child is currently using:

Is your son or daughter allergic to any drugs that you know of? (If so please list names):

Supplement/Vitamin Usage – Please list any supplements/vitamins your child is currently taking:

Lifestyle

Dietary Habits: Describe the foods your child normally eats:
BREAKFAST: _____
LUNCH: _____
DINNER: _____
SNACKS: _____

Lifestyle, Cont'd

Does your child consume the following?

If so, how much?

- | | | | |
|-----------------------------------------|-----|----|-------|
| 1. Soda or carbonated beverages? | YES | NO | _____ |
| 2. White flour products? | YES | NO | _____ |
| 3. Fried foods? | YES | NO | _____ |
| 4. Fast foods regularly? | YES | NO | _____ |
| 5. Sweets and/or refined carbohydrates? | YES | NO | _____ |
| 6. Dairy or milk products? | YES | NO | _____ |
| 7. Juice? | YES | NO | _____ |
| 8. Meat/Fish? | YES | NO | _____ |

Is your child a vegetarian? YES NO

How much water does your child drink daily? _____

Are there smokers in your child's home? YES NO

Is your child physically active daily? YES NO

Please list what types of physical activity and/or sports that your child participates in:

History

As a baby, did your child have colic? YES NO

As a baby, how was your child fed? (Please circle breast or formula)

BREAST How long? _____

FORMULA What kind? _____ How long? _____

Does your child have a history of ear infections? YES NO

If yes, at what age did the first earache occur? _____

How frequently did/does your child have earaches? _____

In which ear do your child's earaches/infections usually occur? RIGHT LEFT BOTH

Were/Are your child's earaches/infections generally treated with antibiotics? YES NO

Is your child allergic to anything? YES NO

If yes, please explain: _____

Does your child have asthma? YES NO Any history of anemia? YES NO

Has your child been vaccinated? YES NO

Has he/she been vaccinated recently? YES NO

If yes, please list any known reactions to past or recent vaccinations: _____

Please list any hospital procedures/surgeries that your child has had: _____

History, Cont'd

Are there any known health conditions that your child has been diagnosed with? YES NO
If yes, please explain: _____

Sleep

How well does your child sleep?

- Well Trouble falling asleep Trouble staying asleep Insomnia

What is the average number of hours your child most often sleeps each night? _____

When your child wakes in the morning does he/she still feel tired? YES NO
If yes, how often? _____

Do you keep your child's room completely dark at night? YES NO

Does your child take naps? YES NO

How often would you say your child has nightmares, if at all? NEVER SOMETIMES OFTEN

Signs & Symptoms (INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). **If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.**

Section 1:

| | | | |
|------------------------------------------|---|---|---|
| Does your child experience bloating? | 1 | 2 | 3 |
| Fullness for extended time after meals? | 1 | 2 | 3 |
| Fatigue or low energy after eating? | 1 | 2 | 3 |
| Does he/she experience indigestion? | 1 | 2 | 3 |
| Uncomfortable/adverse reactions to food? | 1 | 2 | 3 |
| Weight gain / weight loss? (circle) | 1 | 2 | 3 |
| Trouble losing weight? | 1 | 2 | 3 |
| Belching/gas? (circle) | 1 | 2 | 3 |
| Stomach burning/nausea? (circle) | 1 | 2 | 3 |

Signs & Symptoms, Cont'd (INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). **If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.**

Section 2:

- Sweet cravings/carbohydrate cravings? (circle) 1 2 3
- Constant hunger? 1 2 3
- Never hungry/anorexia? (circle) 1 2 3

Section 3:

- Does your child suffer with constipation? 1 2 3
- Light colored stool? 1 2 3
- Loose stools? 1 2 3
- Diarrhea? 1 2 3
- Persistent gas? 1 2 3
- Digestive problems? 1 2 3
- Frequent urination? 1 2 3
- Bedwetting? 1 2 3

Section 4:

- Low mood/depression? 1 2 3
- Irritability? 1 2 3
- Anxiety? 1 2 3
- Anger/aggression? 1 2 3
- Nervousness? 1 2 3
- Overly reactive? 1 2 3
- Short fuse? 1 2 3
- Behavior problems? 1 2 3
- Fear? 1 2 3

Section 5:

- Discouragement/pessimism? (circle) 1 2 3
- Decreased interest in activities/relationships? 1 2 3
- Decreased initiative/motivation/drive? 1 2 3
- Decreased productivity at school or home? 1 2 3

Signs & Symptoms, Cont'd (INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.

Section 6:

| | | | |
|---------------------------------|---|---|---|
| Concentration problems? | 1 | 2 | 3 |
| Poor memory? | 1 | 2 | 3 |
| Foggy thinking? | 1 | 2 | 3 |
| Increased fatigue? | 1 | 2 | 3 |
| Lowered self-esteem/self image? | 1 | 2 | 3 |
| Sadness? | 1 | 2 | 3 |
| Crying? | 1 | 2 | 3 |
| Reserved/withdrawn? | 1 | 2 | 3 |

Section 7:

| | | | |
|--------------------------------------|---|---|---|
| Decrease in stamina or poor stamina? | 1 | 2 | 3 |
| Decrease in athletic performance? | 1 | 2 | 3 |
| Muscle soreness/weakness? | 1 | 2 | 3 |
| Body/joint aches? | 1 | 2 | 3 |
| Persistent leg cramps? | 1 | 2 | 3 |
| Growing pains? | 1 | 2 | 3 |
| Headaches/migraines? (circle) | | | |

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment, and Healthcare Operations

I _____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is available upon request. I may also request a copy from this office at anytime via US mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Printed name of Patient

Date

Signature of Patient, Parent, or legal guardian

Witness

Payment Policy

___ **CASH:** Payment in full is expected at the time the service is done.

___ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment of benefits to this office for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance.

___ **ALL INSURANCE AND MEDICARE:** I hereby authorize this office to release any medical or incidental information that may be necessary for medical care or processing applications for financial benefits. If I receive payment from my insurance carrier during the period which the clinic has accepted assignment of benefits, I will bring the check into this office within 3 days of receipt and endorse it over to the office. Failure to do this may result in collection action. If I discontinue care for any reason other than discharge by the doctor, I will be responsible for any unpaid balance regardless of any claims submitted to my insurance company, at the time I discontinue care. This office does not promise that any insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be my responsibility to pay all the charges and pursue reimbursement from the insurance company on my own.

___ **CANCELLATION POLICY:** 24 hour notice must be given to cancel an appointment. In case of a short notice or no notice cancellation, a \$25.00 cancellation fee will be charged.

___ **PAST DUE ACCOUNT POLICY:** After 60 days of non-payment, a \$25.00 late fee will be added to my account to be compounded monthly. If necessary, my account will be turned over to a collections agency. As a last resort, the office will take legal action and all reasonable attorney and court fees incurred to collect fees due to this office will be added to my account and I will be responsible.

****I have read and understand the above and hereby agree to abide by the provisions as specified. Thank you for your cooperation and understanding.**

Patient Name: _____

Signature of Patient, Parent, or Legal Guardian

Date

Information Release Form

Name: _____ Date: _____

Contact Preferences

By signing below I give permission to Whole Health Chiropractic to leave messages regarding my appointments, nutrition, or other health information via the following methods unless otherwise specified (strike through any methods you wish to not receive).

- Voice Message on Home Number / Cell Number / Business Number
- Text Message to provided number
- Email Message to provided email address
- Demand Force – email/text appointment reminders, newsletters, birthday wishes, etc.
 - Contact settings can be changed by following the instructions in an email or text.

Sign: _____ Date: _____

Digital Contact Release

I understand that Whole Health Chiropractic seeks to be available for questions and further clarification that may be required through email, texting, Facebook messages, or other digital outlets. I also understand that many of these forms may not be compliant with HIPAA (health information portability and accountability act) privacy standards for medical information. By signing I agree to allow Whole Health Chiropractic staff and doctors to discuss my health information with me via these non-secure forms. Nothing will be intentionally made public.

Sign: _____ Date: _____

*By refusing signature, you are declining contact through these forms and all health information questions must be addressed by appointment or phone call.

Testimonial Release

Whole Health Chiropractic enjoys using testimonials to aid in patient awareness and education. I understand that by becoming a patient, my story may be told in written or oral form including online media. I understand that I have the right to determine the level of information revealed that connects me to the testimony personally including my name, initials, location, etc. I am aware that I can request the removal of my identifying information at any time.

By signing below I give Whole Health Chiropractic the authority to use my:

(Please select all that apply)

- My initials
- My name
- Nothing (pseudonym)
- Picture (if provided)

Sign: _____ Date: _____

Informed Consent to Chiropractic and Associated Care

SERVICES

–Chiropractic & Manual Therapy: Chiropractic treatment will involve the doctor using their hands or an instrument to move your joints in order to impact the nervous system, which regulates the entire body. This may or may not result in a harmless “pop” sound, depending on the various techniques used. Manual therapies, such as myofascial reconfiguration and trigger point release, will involve the use of hands or tools to break up adhesions and impact the nervous system. Risks: The risks of Chiropractic and manual therapies include mild skin irritation, soreness or bruising. Extremely rare risks can include fracture, strain, sprain, stroke, or possible injury to intervertebral discs, nerves, the spinal cord or arteries in the neck. These risks are diminished by performing a thorough history, risk assessment, and examination.

–Acupuncture & Meridian Therapy: Acupuncture involves the use of needles to stimulate points on the body known to produce certain effects. Meridian therapy is the study of the energy systems in the body as it pertains to Traditional Chinese and other Eastern medicine practices, which includes acupressure, auriculotherapy, and some use of traditional herbal principles. Risks: The risks of Acupuncture therapy include bruising, numbness or tingling near needle sites for a few days, dizziness or fainting. Rare risks include organ puncture or infection. These risks are diminished by using sterile, disposable needles and practicing in a clean and safe environment.

–Functional Nutrition & Supplementation: Nutritional evaluation may include history, signs and symptoms analysis, laboratory testing (serum, skin, hair, urine, stool, saliva, etc), muscle testing, and bio-resonance testing. Recommendations may include lifestyle modification, dietary changes, and supplement suggestions. Risks: The risks of dietary and certain supplemental care may result in diarrhea, constipation, nausea, gas, headache, rashes or allergic response, toxicities, and deficiencies. These are diminished by taking ownership of the foods eaten and supplements taken, following general recommendations, and informing my medical and other doctors of any nutritional supplements or dietary changes. A full history, including medications, family and social history, is taken.

–Bio-resonance Testing: Bio-resonance testing is a form of bio-feedback that allows deeper analysis of the human body. It is not licensed by the FDA to diagnose or treat any condition and is not employed by most practitioners in this way. All decisions are ultimately made based on clinical and laboratory information regarding therapies or nutritional recommendations.

Alternatives: Alternatives to Chiropractic and these associated methods include medical care (including medications and/or surgical procedures), massage therapy, physical therapy, over-the-counter medication, and other self-care.

Risks of Non-Treatment: Delay of treatment may allow for progression of the current condition or reduction in healing with greater likelihood of formation of chronic pain or lifestyle limitations.

CONSENT TO TREATMENT

I hereby desire and request care via the methods above from Whole Health Chiropractic for myself or the patient, named below, for whom I am legally responsible. I have been informed of the risks, benefits and alternatives to Chiropractic, manual therapy, acupuncture, nutritional and herbal modification, and biofeedback testing. I am aware it is my sole responsibility to inform my physician to the best of my knowledge any health history or risk information so that my care plan may be adjusted accordingly. I also accept responsibility for seeking appropriate care for any conditions that arise before or after beginning care, including but not limited to pregnancy, diabetes, and any communicable diseases.

I understand that my doctor at Whole Health Chiropractic cannot make any promises or guarantees regarding a cure or improvement of my condition. I understand they will share their professional opinion regarding potential results from Chiropractic care and will discuss treatment options with me, but it is my responsibility to remain informed and in charge of the direction of my care.

I have been given the opportunity to ask pertinent questions regarding the above information. I understand that I am responsible for payment at time of service. My signature signifies that I have read this document and understand its purpose. I release Whole Health Chiropractic and its employed or affiliated practitioners from any liability.

Patient Name (print): _____

Legal Guardian (required to sign if patient under 18): _____

Sign: _____

Date: _____

Witness: _____

Date: _____
