Adult Application for Care

RESTORE FAMILY CHIROPRACTIC

Are you over 18? ◯ Y ◯ N Date: _____

Is this appointment alone or with a family member?

◯ Family Member (same day) ◯ Family Member (different day) ◯ Alone

Biological Sex:

◯ M ◯ F

Confidential Personal Information

First Name: _____ Last Name: _____ Date Of Birth: _____

Cell: _____ Other Phone: _____ Email: _____

Street Address _____ City/State _____ Zip _____

Preferred Contact Method: ◯ Text me ◯ Call me

Occupation _____ Employer _____

Emergency Contact: First Name: _____ **Last Name:** _____

Phone: _____ **Relationship:** _____

Marital Status

◯ Single ◯ Engaged ◯ Married

◯ Separated ◯ Divorced ◯ Widowed

Name of Spouse: _____

How many children do you have? _____ How old are they? _____

Does your child or spouse/partner already have an appointment?

☐ Yes, in the same week as mine ☐ No, but I'd like to schedule them

☐ Yes, I was referred by them ☐ No, but let's talk about that later

Previous Treatment

Have you ever seen a chiropractor before: ◯ Yes ◯ No

If yes, where? _____ When was your last visit? _____

Did they take Xrays? ◯ Yes ◯ No

How often were you adjusted?

◯ 2-3x/week ◯ Weekly ◯ Monthly ◯ Only when it hurt

Have you sought treatment elsewhere for this condition? ◯ Yes ◯ No

If yes, where? _____

How did you hear about us?

◯ Referral from Current Patient ◯ Google search ◯ I saw you at an event

◯ Facebook/Instagram ◯ I saw your sign ◯ Other: _____

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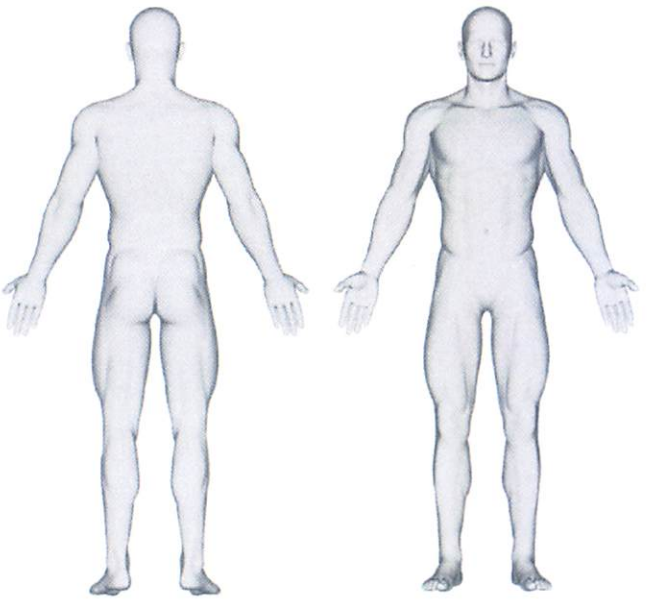
Please mark your PRIMARY complaint on this diagram using the following Guide:

What is the purpose of today's appointment?

- ◯ Wellness Checkup
- ◯ Current or recent symptoms
- ◯ Recent injury or accident

S = Stabbing
T = Tingling
A = Aching
R = Radiating
B = Burning
D = Dull
N = Num

Please mark the areas on the Diagram with the following LETTERS to describe your CURRENT symptoms:



If you are already experiencing a symptom, what is it in 3-5 words?

_____

_____

How long ago did you first notice it? _____

I first noticed this symptom:

◯ Suddenly ◯ Gradually ◯ post-injury

How often do you Feel it? ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittenty

What were you doing when you first noticed it? _____

How Severe is it? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Why did you decide to get it checked? Why now? _____

Is this condition: ◯ Getting worse ◯ Getting Better ◯ Neither better nor worse ◯ Intermittent

What makes it worse? _____

What makes it better? _____

Do you have a SECONDARY complaint? What is it in 3-5 words? _____

What makes it better? _____

How long ago did you first notice it? _____

I first noticed this symptom: ◯ Suddenly ◯ Gradually ◯ post-injury

How often do you Feel it? ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittenty

How Severe is it? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Is this condition: ◯ Getting worse ◯ Getting Better ◯ Neither better nor worse

What makes it worse? _____

What makes it better? _____

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Symptom Review

	Past	Present		Past	Present
Concussions	☐	☐	Swollen/Painful Joints	☐	☐
Dizziness	☐	☐	Foot/Knee problems	☐	☐
Neck Pain	☐	☐	Double vision/blurred vision	☐	☐
Jaw Pain	☐	☐	Hearing loss/ear pain	☐	☐
Shoulder Pain	☐	☐	Irritability/depression	☐	☐
Upper Back Pain	☐	☐	ADD/ADHD	☐	☐
Low Back Pain	☐	☐	Headaches/Migraines	☐	☐
Hip Pain	☐	☐	Numbness in arms/hands	☐	☐
Scoliosis	☐	☐	Digestive Problems	☐	☐
Low Energy	☐	☐	Trouble Sleeping	☐	☐
Ulcers	☐	☐	Tingling in arms/hands	☐	☐
Allergies	☐	☐	Low/High blood pressure	☐	☐
Seizures	☐	☐	Frequent cold/flu	☐	☐

Trauma History

Briefly detail any accidents, injuries, or surgeries _____

_____

Did you/Do you play sports? ◯ Y ◯ N

How many hours per day do you spend at a desk or computer? _____ Phone? _____

Do you typically wake up feeling: ◯ Refreshed and Ready ◯ Stiff and Tired

Do you spend most of your time at work or play:

◯ Sitting ◯ Standing ◯ Manual Labor ◯ On the computer

◯ Stressed ◯ Driving ◯ My life is sedentary ◯ On the phone

Are you currently pregnant? _____ Est due date? _____

Health concerns during pregnancy? _____

Number of past pregnancies _____

Please list any significant family medical history: _____

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Life Effect of your Symptoms

	No Effect	Painful (Can do)	Painful (limits)	Unable to Perform
Bending	☐	☐	☐	☐
Computer Work	☐	☐	☐	☐
Gardening	☐	☐	☐	☐
Sports/Recreation	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Carrying things	☐	☐	☐	☐
Getting Dressed	☐	☐	☐	☐
Lifting things	☐	☐	☐	☐
Pushing things	☐	☐	☐	☐
Sitting long periods	☐	☐	☐	☐
Standing long periods	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting to Standing	☐	☐	☐	☐
Doing chores	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Self Care	☐	☐	☐	☐

How committed are you to fixing this issue? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Health and Condition Goals

Briefly, what would be different if your symptoms were gone?

_____

What are your 1 YEAR health goals if your condition improves or symptoms are eliminated?

_____

What are your 5 YEAR health goals if your condition improves or symptoms are eliminated?

_____

What would you like to gain from chiropractic care?

_____

Toxicity

Please rate your stress level in the following categories:

	None	Some	Moderate	High	Severe
Home	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯
Money	◯	◯	◯	◯	◯
Health	◯	◯	◯	◯	◯
Family	◯	◯	◯	◯	◯

Please rate your consumption of each:

	None	Some	Moderate	A lot
Water	◯	◯	◯	◯
Alcohol	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯

Please list medications:

_____

_____

Please list supplements:

_____

_____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Restore Family Chiropractic** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ Witness Initials

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on___/___/___Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ Witness Initials

Patient or Authorized person's Signature Date

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Additional Items:

1) May we confirm your appointments by email, text or phone?	Yes	No
2) May we leave a message on your answering device at home or cell phone?	Yes	No
3) May we discuss your condition with any members of your family?	Yes	No

If yes, provide names: _____

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ _____
Patient Printed Name Patient Signature or legal representative

_____ _____
Date If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient, but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date