Re-Activation Updated Health Record

Name: _____ Guardian's Name (if minor): _____

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

Birth Date: _____ Age: _____ Ethnicity: _____ Gender: ☐M ☐ F

Cell Phone: _____ Home Phone: _____

Work Phone: _____ E-mail: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ City: _____ Marital Status: ☐M ☐S ☐W ☐D

Emergency Contact: _____ Relationship: _____ Phone #: _____

Are you insured? ☐Y ☐N Insurance Company: _____ ID#: _____ Group #: _____

Cardholder's Name: _____ Cardholder's Date of Birth: _____

Social Security #: _____ Is this visit the result of a work or auto injury? ☐Y ☐N

Reason for This Visit

Describe the purpose of this visit: _____

_____

How did this condition begin? _____

_____

When did this condition begin? _____

_____

Is this condition: ☐Getting worse ☐Not changing ☐Getting better Is this condition: ☐Constant ☐Comes and Goes

What makes it **better**? (rest, ice, heat, positioning, etc.) _____

What makes it **worse**? (circle all that apply)

Sitting	Changing positions	Laying/Sleeping	Going up/downstairs
Standing	Twisting	Reaching	Deep breaths
Walking	Lifting	Bending	Cough/Sneeze/Bowel movements

Other: _____

Does the pain: ☐Stay in one spot ☐Travel to other areas If it travels, where? _____

Describe the pain: Ache/sharp/shooting/burning/pins and needles/numbness Other: _____

Is your pain worse in the AM or PM (circle one)? Or no difference?

Please rate the severity of your pain when it's at its **best** (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Please rate the severity of your pain when it's at its **worst** (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Please rate the **average** severity of your pain (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Has this condition occurred before? If yes, how often?: _____

Have you ever seen other doctors/massage/acupuncture, etc. for this condition? ☐Y ☐N Name(s): _____

Types of Treatment: _____

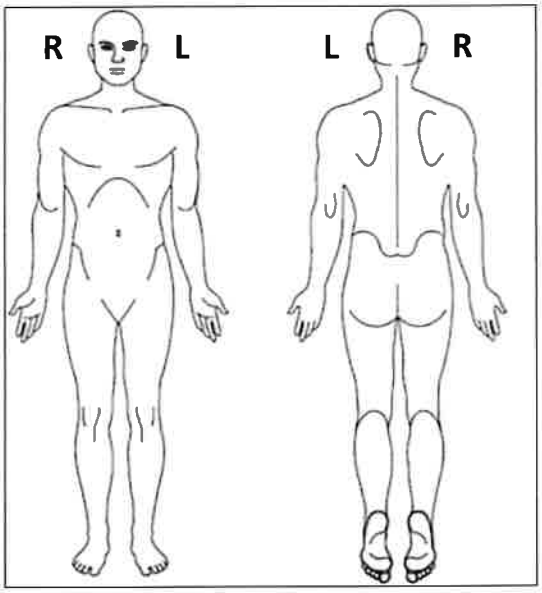
Did it help? ☐ Yes ☐ No ☐ Temporary Relief

Other injuries: (i.e. car accidents, falls, etc.) _____

_____

Any other odd/unusual changes in the last few months: (i.e. unexplained weight loss/gain, fatigue, changes in bowel/bladder function, etc.) _____

Please mark the location of your pain on the drawing (right) →



Current Medications and Supplements

Please circle all that apply

High Blood Pressure	Prescription Pain Medication	Insulin	Muscle Relaxers
High Cholesterol	Thyroid Medication	Blood Thinners	Anti-depressant
Anti-anxiety	Anti-biotics	Allergy	Medical Marijuana
OTC NSAIDs (Tylenol, Motrin, etc.)		Steroids/Anti-inflammatory	
Multivitamin	Probiotic	Omegas	Fiber
Vitamin C	Vitamin D	Calcium	Turmeric

Other: _____

_____

Updated Health History

Please list any major health changes since your last visit: _____

_____

Surgeries and Dates since last visit: _____

_____

Any other changes since your last visit: _____

_____

Smoking: ___ packs/day ___ Former ___ Never

Alcohol: ____ drinks/week

Coffee/Caffeine: ___ cups/day

Water: ___ oz/day

Do you exercise? If yes, what type and how often? _____

*****For Women:***

Last Menstrual Cycle: _____

Are you taking birth control? _____ *Are you pregnant?* _____ *If yes, when are you due?* _____

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. (164.520)

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to certain individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions.

Your Right to Revoke Your Authorization: You may revoke your consent to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorize you to use and disclose my information in the manner described above, to my primary care physician, and to:

Name: _____ Relationship: _____

I have read your consent policy and agree to its terms. Initials: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to adjust/manipulate your joints. You may hear a "pop" or "click" like when a knuckle is "cracked", and you may feel movement in the joint. Various ancillary procedures, such as hot or cold packs, electric stimulation, therapeutic ultrasound, and traction as well as exercise instruction and other modalities may also be used. There are inherent risks in all treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there is a very low incidence of complication associated with chiropractic services, and anyone undergoing adjustment or manipulative therapy procedures should know the possible hazards and complications which may be encountered. These include, but are not limited to fractures, disc injuries, stroke, dislocations, sprains, and those related to physical aberrations unknown or reasonably undetectable by the doctor.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgement; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgement during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make further rehabilitation more difficult or impossible. Concerns or questions: Please ask your doctor to explain any concerns about treatment you may have.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on my dependent/charge, by the licensed Doctor of Chiropractic (D.C.) employed or engaged in practice at **East West Chiropractic**.

I have read the above consent to chiropractic care. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. Initials: _____

Emails and Appointment Reminders

We may need to use your name, address, phone number and your clinical records to contact you with appointment reminders (text and email), information about treatment alternatives, or other health related information that may be of interest to you. This information may also be used for the purpose of sending birthday/holiday cards and messages, occasional newsletters, etc. If this contact is made by phone and you do not answer, a message will be left on your answering machine. By signing this, you are giving us authorization to contact you with these reminders and information. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, and other health related information or marketing at any time. Telephone calls, text messages, and emails may be monitored for quality control.

I authorize you to use and disclose my health information in the manner described above. Initials: _____

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of signature on my insurance submissions.

Name (Print): _____ **Signature:** _____ **Date:**

OFFICE POLICY

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY
Multiple appointments will be scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts; and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within **7 days** of any cancellation.

This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice. All Text and E-mail reminders are sent as a courtesy, patients are still responsible for keeping track of their appointment times.

When entering the office on any given visit, please go directly to the front desk and "sign-in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY

1. It is our office policy that all services rendered in this office are billed to your insurance company, if applicable. If for any reason your insurance company rejects you claims, you are personally responsible for all charges incurred.

2. All payments, including co-pays and deductibles, are expected at the time of service or at the end of each week. Patients' balances may not exceed $150 at any time.

3. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1 ½% per month.

4. **A charge of $20 will be incurred for all appointments that are missed or those not cancelled with 24 hour notice.**

5. **A charge of $40.00 will be incurred for all 60 minute massage appointments that are missed or those not cancelled with 24 hour notice.**

6. **A charge of $20.00 will be incurred for all 30 minute massage appointments that are missed or those not cancelled with 24 hour notice.**

PATIENT NAME_____

PATIENT'S SIGNATURE_____

DATE_____