PROVIDENCE CHIROPRACTIC HEALTH PROFILE

Name_____Date____/____/____Age_____ Male/Female

Address_____City_____State____Zip_____

Phone: Home_____ Cell_____ Date of Birth____/____/_____

Email Address_____

For confirming appointments, do you prefer? TEXT or EMAIL

Occupation_____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you? _____

## *LIST YOUR HEALTH CONCERNS BELOW*

| | Health Concerns: List according to severity | Rate of Severity 1 = mild 10 = unbearable | When did this episode start? | If you had the condition before, when? | Did the problem begin with an injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? ____

CHIROPRACTOR? _____ MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN?_____

## *CIRCLE ANY AND ALL CURRENT PROBLEMS YOU HAVE*

| | | | | |
|---|---|---|---|---|
| *DIZZINESS* | *THROAT ISSUES* | *KIDNEY PROBLEMS* | *LIVER DISEASE* | *NERVOUSNESS* |
| *HEADACHES* | *THYROID PROBLEMS* | *MID BACK PAIN* | *SHOULDER PAIN* | *EPILEPSY* |
| *VERTIGO* | *ASTHMA* | *IRRITABLE BOWEL* | *CHRONIC FATIGUE* | *DISC PROBLEM* |
| *EAR INFECTIONS* | *ULCERS* | *SCIATICA* | *LUPUS* | *INFERTILITY* |
| *GRATING IN NECK* | *NUMBNESS IN ARMS* | *NUMBNESS IN LEGS* | *FIBROMYALGIA* | *GASTRIC REFLUX* |
| *TMJ* | *NUMBNESS IN HANDS* | *NUMBNESS IN FEET* | *CHEST PAIN* | *NAUSEA* |
| *NECK PAIN* | *MENSTRUAL DISORDER* | *LOW BACK PAIN* | *ARM PAIN* | *OTHER*_____ |
| *MIGRAINES* | *HEART DISORDERS* | *HIP PAIN* | *ADD/ADHD* | _____ |
| *STIFFNESS IN NECK* | *STOMACH DISORDERS* | *LEG PAINS* | *GERD* | _____ |
| *CHRONIC SINUS* | *BLADDER PROBLEMS* | *KNEE PAIN* | *ANXIETY* | _____ |

## ***CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:***

**STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES**

**LIST SURGICAL OPERATIONS AND YEARS**_____

_____

**LIST ALL Over the Counter & PERSCRIPTION MEDICATIONS YOU ARE ON:**

_____

_____

**WHEN WAS YOUR LAST AUTO ACCIDENT**_____

**HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____YES_____NO**

**IF YOU HAVE, DR. & DATE**_____

**HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS_____YES ____NO FRACTURED A BONE? ____YES_____NO**

**IF YES, PLEASE DESCRIBE**_____

**OTHER TRAUMA:**_____

**SOCIAL HISTORY**

**1. SMOKING:** ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. EXERCISE:** How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE**

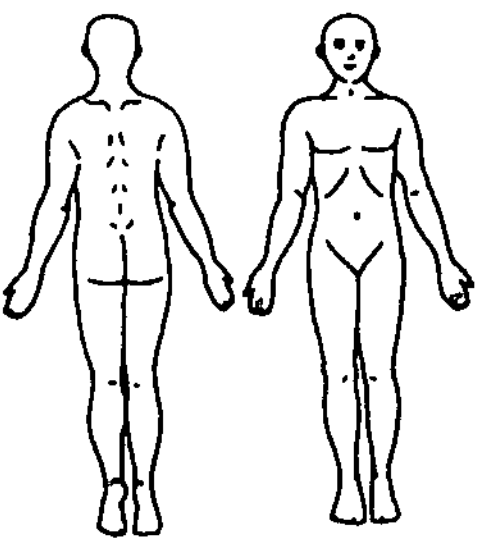
_____

**4. WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:**

_____

_____

***PLEASE MARK** the areas on the Diagram with the following **letters**
to describe your symptoms:
**R = Radiating B = Burning D = Dull A = Aching N = Numbness**
**S = Sharp/ Stabbing T= Tingling**



What relieves your symptoms?

_____

What makes them feel worse?

_____

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

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**1 – What is your pain RIGHT NOW?**

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

**2 – What is your TYPICAL or AVERAGE pain?**

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

**OTHER COMMENTS:**

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## Practice Member Information (Must Be Completed Before Services Can Be Rendered)

NAME:_____
First Middle Last

PHONE: Home: _____ Cell: _____ Work: _____

Social Security Number:_____ Marital Status:_____

Date of Birth: _____

Contact In Case of Emergency: _____ Phone #: _____

**NAME OF PRIMARY INSURANCE CARRIER:** _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

**NAME OF SECONDARY INSURANCE CARRIER:** _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

## Insurance Policies and Fee Schedule

- **Consultation** - Includes practice member history. This service is complementary.
- **Assessment** (new or established practice member) - Includes one or more of the following: thermography, surface electromyography, heart rate variability, range of motion, motion and/or static palpation, leg checks $50-$100.
- **Chiropractic Adjustment** – The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $50-$90.
- **X-Rays** - Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can be used to indicate progress after a period of care. $80/view.
- **Video Fluoroscopy** - A radiographic spinal motion study performed in combination with x-rays to determine a misalignment/subluxation. This may be used to indicate progress after a period of care. $250 for full study.

## Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jessica Harden, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ Date_____

# FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

| CONDITION | SPOUSE | SON | DAUGHTER | MOTHER | FATHER |
|---|---|---|---|---|---|
| ARM PAIN | | | | | |
| ARTHRITIS | | | | | |
| ASTHMA | | | | | |
| ADD/ADHD | | | | | |
| ALLERGIES | | | | | |
| BACK TROUBLE | | | | | |
| BED WETTING | | | | | |
| CANCER | | | | | |
| CARPAL TUNNEL | | | | | |
| DECEASED | | | | | |
| DIABETES | | | | | |
| DIGESTIVE PROBLEMS | | | | | |
| DISC PROBLEMS | | | | | |
| EAR INFECTIONS | | | | | |
| FIBROMYALGIA | | | | | |
| HEADACHES | | | | | |
| HEARTBURN | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| HIP PAIN | | | | | |
| LEG PAIN | | | | | |
| MENSTRUAL DISORDER | | | | | |
| MIGRAINES | | | | | |
| NECK PAIN | | | | | |
| SCOLIOSIS | | | | | |
| SHOULDER PAIN | | | | | |
| SINUS TROUBLE | | | | | |
| TMJ | | | | | |

# INFORMED CONSENT FOR CHIROPRACTIC CARE

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 TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A 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 OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

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**I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.**

_____
**PRINT PATIENT'S NAME HERE**

_____ _____
**PATIENT'S SIGNATURE** **DATE**

**IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW**

## WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. JESSICA HARDEN AND ANY AND ALL PROVIDENCE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY PROVIDENCE CHIROPRACTIC. I WILL ALSO NOTIFY THE TEAM IF ANOTHER GUARDIAN SHARES THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH SERVICES, AND I WILL ASSIST IF WRITTEN PREMISSION FROM THE OTHER GUARDIAN IS REQUIRED.

_____ _____
**DATE** **GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR /CHILD**

_____ _____
**WITNESS SIGNATURE (OFFICE STAFF)** **DATE**

## Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by 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.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic 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 procedures applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

### *Notice of Privacy Practices Acknowledgement*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). 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 acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed and carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
(Signature) (Date)

PLATINUM ID

# X-RAY AUTHORIZATION

**AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.**

**AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.**

**THE FEE FOR COPYING YOUR X-RAYS AND VIDEO FLUOROSCOPY STUDY ON A DISC IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.**

**DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT DURING REGULAR PRACTICE HOUR DAYS.**

**PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF PROVIDENCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.**

**BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

PRINT YOUR NAME HERE _____ DATE OF BIRTH _____

SIGNATURE _____ DATE _____

**FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT PROVIDENCE CHIROPRACTIC.**

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐F

| Radiography Taken: | |
|---|---|
| ☐ Video Spinal Series | ☐ Other View (s): _____ |
| ☐ Lateral Cervical | |
| ☐ A-P Cervical Thoracic | ☐ Study to be sent to DACBAR |
| ☐ A-P Open Mouth | |
| ☐ A-P Thoracic | ☐ Additional notes: _____ |
| ☐ Lateral Thoracic | _____ |
| ☐ A-P Lumbar Pelvic | _____ |
| ☐ Lateral Lumbar Pelvic | _____ |
| | _____ |
| | Setup: _____ |
| | Study performed by: _____ |
| | Radiographs reviewed by: _____ |