

INTEGRAL CHIROPRACTIC CO. HEALTH PROFILE

PATIENT DEMOGRAPHICS

Today's Date: ____ / ____ / ____ PMID: _____

Name: _____ Birth Date: ____ / ____ / ____ Age: ____ Male Female

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

E-mail: _____ Home Phone: _____ Cell Phone: _____

Cell Phone Provider: _____ Work Phone: _____ Marital Status: Single Married

Employer: _____ Occupation: _____

Social Security Number: _____ Spouse's Name: _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

HISTORY OF COMPLAINT

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? YES / NO CHIROPRACTOR? MEDICAL DOCTOR? OTHER

WHO AND WHEN? _____

CIRCLE 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 |
| NAUSEA | NUMBNESS IN ARMS | NUMBNESS IN LEGS | FIBROMYALGIA | GASTRIC REFLUX |
| TMJ | NUMBNESS IN HANDS | NUMBNESS IN FEET | CHEST PAIN | OTHER _____ |
| NECK PAIN | MENSTRUAL DISORDER | LOW BACK PAIN | ARM PAIN | _____ |
| MIGRAINES | HEART DISORDERS | HIP PAIN | ADD/ADHD | _____ |
| ANXIETY | STOMACH DISORDERS | LEG PAINS | BED WETTING | _____ |
| CHRONIC SINUS | BLADDER PROBLEMS | KNEE PAIN | ALLERGIES | _____ |

CIRCLE YOUR TOP 3 HEALTH GOALS:

LESS/NO PAIN TAKING LESS OR NO MEDICATIONS PREVENT SURGERY INCREASED LONGEVITY RETURN TO WORK/INCREASED PRODUCTIVITY ABILITY TO ENJOY HOBBIES AGAIN SPEND TIME WITH FAMILY OTHER _____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD: (IF NOTHING APPLIES PLEASE WRITE N/A HERE _____)

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

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON:

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO IF YES, WHEN _____ WHY? _____

_____ **CHIROPRACTOR'S NAME** _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE: _____

OTHER TRAUMA: _____

HOW WOULD YOU RATE YOUR HEALTH? (CIRCLE ONE): EXCELLENT GOOD AVERAGE FAIR POOR

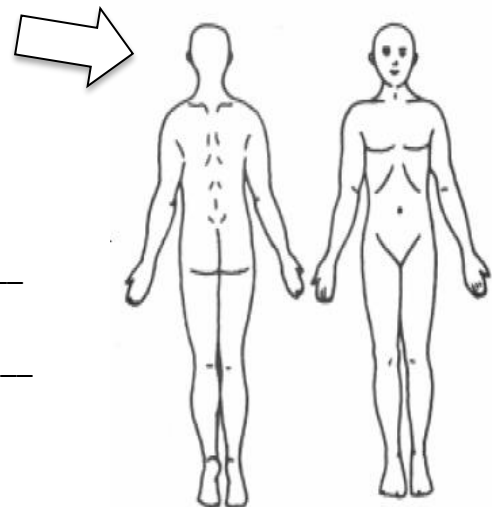
LIST WHAT YOU ARE CURRENTLY DOING FOR YOUR HEALTH: _____

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? _____



SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- 3. **Recreational Drug use** Daily Weekends Occasionally Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:**

ACTIVITIES OF DAILY LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

I hereby authorize payment to be made directly to Integral Chiropractic Co. for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Integral Chiropractic Co. for any and all services I receive at this office.

Practice Member or Authorized Person's Signature

____/____/____
Date Completed

Examiner's Signature

____/____/____
Date Form Reviewed

FAMILY HEALTH HISTORY

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

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					

Practice Member Name

____/____/____
Date Completed

QUADRUPLE VISUAL ANALOGUE SCALE

Practice Member Name

____ / ____ / ____

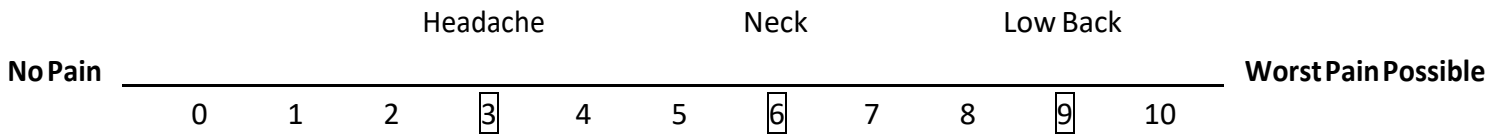
Date Completed

Please read carefully:

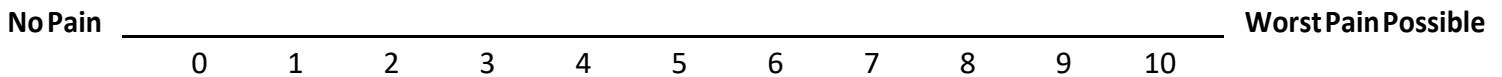
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question (1,2,3, and 4) for each individual complaint (by writing complaint above number line) and indicate the score (by circling a number) for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst by filling out the form below.

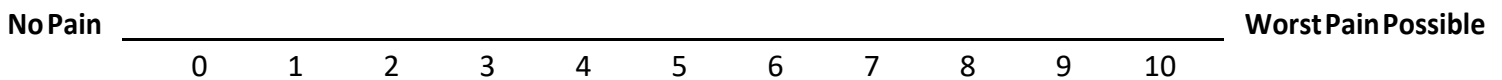
Example:



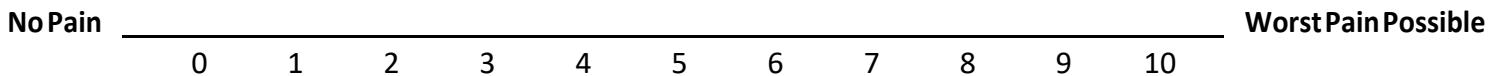
1 – What is your pain RIGHT NOW?



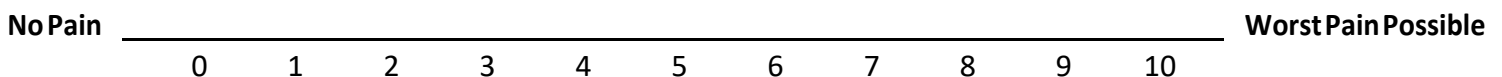
2 – What is your TYPICAL or AVERAGE pain?



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



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



OTHER COMMENTS: _____

Examiner’s Signature

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 Integral Chiropractic Co. 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.

Practice Member or Authorized Person's Signature

____ / ____ / ____
Date Completed



Witness Initials

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.

Practice Member or Authorized Person's Signature

____ / ____ / ____
Date Completed



Witness Initials

TERMS OF ACCEPTANCE

In order to provide 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:

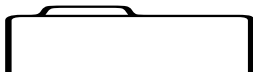
- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring 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 procedure 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 questions 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 types 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 through chiropractic care.
- G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

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.

Practice Member or Authorized Person's Signature

___ / ___ / ___
Date Completed



Witness Initials

INTEGRAL CHIROPRACTIC CO. NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is \$20.00. This fee must be paid in advance. (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 doctor does 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.)

Patient initials: _____ - retaining page 1 of 2

I have received a copy of Integral Chiropractic Co. Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Print Name

____ / ____ / ____
DOB

Practice Member or Authorized Person's Signature

____ / ____ / ____
Date Completed



Witness Initials

**Medical Information Release Form
(HIPAA Release Form)**

Print Name

____/____/____
DOB

Release of Information:

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call my home my work my mobile number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your

call _____

The best time to reach me is (*day*) _____ between (*time*) _____

Practice Member or Authorized Person's Signature

____/____/____
Date Completed



Witness Initials