

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

Child Personal History

Name: _____

Insurance Carrier: NA _____

Birth Date: _____ Age: _____

Group #: _____

Social Security #: _____

Health Card ID#: _____

Sex: M / F

Insured Person's Name: _____

Guardian: _____

Insured Date of Birth: _____

Address: _____

Insured Social Security: _____

City: _____ State: _____ Zip: _____

Insured Relationship: _____

Home Phone #: _____

Referred to this office by: _____

Cell Phone #: _____

Have you had previous Chiropractic care? Y N

Work Phone #: _____

Name of previous Chiropractor: _____

Email Address: _____

Time under care: _____

CHIEF COMPLAINT – HPI FORM

Chief Complaint (Why you're here): _____

▼ ▼ ▼ Please Outline areas affected ▼ ▼ ▼

Describe: Sharp Dull Throbbing

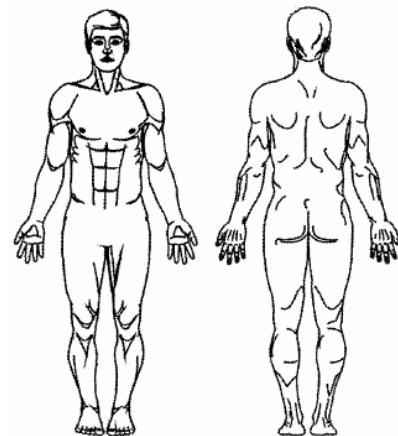
Crushing Stabbing Local Radiating

Migraine Tension Hormonal Sinus

Timing: Constant Intermittant

Pain Level (circle):

None 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Disabling



WHEN and HOW did this **FIRST** begin? (Example: fall, auto injury, sports trauma, repetitive motion, etc):

Medications: What medications are you currently taking, and for what conditions? _____

Patient Name: _____

Date: _____

CHILD INFORMATION AND RELEASE

Please check health complaints your child is currently experiencing or experiencing on a recurring basis.

Asthma Headache Ear Infection Colic Allergies Bed wetting

Please check any childhood disease your child has had.

Chicken Pox Measles Mumps Rubella Whooping Cough Ear Infection

Please comment on how often any of the above diseases have occurred and when they occurred:

Pregnancy normal? Yes No Explain: _____

Complications? _____

Delivery: Home Hospital Complications: _____

Medications DURING delivery: _____

Immunizations: (these are OFTEN the cause of various syndromes and diseases due to harmful chemical ingredients such as mercury and formaldehyde, list those received and age): _____

List any surgeries and congenital conditions: _____

TERMS OF ACCEPTANCE CHIROPRACTIC INFORMED CONSENT

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our **ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Initial: _____

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office and what is available today, thanks to progress in spinal health care.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

Initial: _____

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness care: Spinal neglect is so common. It has become an epidemic in our society—despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

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 complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of Parent/Guardian

Date

POLICIES

1. All charges are payable when services are rendered.
2. X-ray film is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary but must be paid upfront.
3. Method of payment you plan to use to take care of today's charges? Cash Check Credit

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand South Alabama Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to South Alabama Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered 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 at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize South Alabama Chiropractic to obtain a credit report if deemed necessary.

Initial: _____

NOTICE OF PRIVACY PRACTICE

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

With my signature below, I give consent for **South Alabama Chiropractic** to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

Open adjusting rooms: We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment after hours or we can set up a phone call to assist you.

To Family and Close Friends Involved in Your Care: Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately and we can refer you to another chiropractor. In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

Requesting Restrictions: You have the right to request a restriction in how we use or disclose your PHI. This must be done in writing. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.

Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes x-rays, medical, and billing records. To inspect and copy PHI, you must submit your request in writing. We will usually respond to your request within thirty (30) days. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If we charge a fee, we will let you know the fee prior to making the copies so that you can withdraw or modify your request before incurring a charge. In addition, we may charge to make copies of your records to send to another health care provider; if so, we will notify you in writing prior to making the copies.

I have reviewed or have had the opportunity to review the Privacy Policy of this practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

Signature

Date

EXAMINATION FINDINGS: DO NOT MARK IN THIS SECTION

Objective Testing

Georges	0 - 2 - 4 - 6 - 8 - 10	Kemps	0 - 2 - 4 - 6 - 8 - 10
Distraction	0 - 2 - 4 - 6 - 8 - 10		
Max Foraminal	0 - 2 - 4 - 6 - 8 - 10		

Posture

Anterior	<input type="checkbox"/>	Thoracic	R	L	
Cervical	R	L	Lumbar	R	L

ROM

C/S Flexion	0 - 2 - 4 - 6 - 8 - 10	T/S Flexion	0 - 2 - 4 - 6 - 8 - 10
C/S Extension	0 - 2 - 4 - 6 - 8 - 10	T/S Extension	0 - 2 - 4 - 6 - 8 - 10
		L/S Flexion	0 - 2 - 4 - 6 - 8 - 10
		L/S Extension	0 - 2 - 4 - 6 - 8 - 10

Palpation

Cervical	0 - 2 - 4 - 6 - 8 - 10	Lumbar	0 - 2 - 4 - 6 - 8 - 10
Thoracic	0 - 2 - 4 - 6 - 8 - 10	Sacral	0 - 2 - 4 - 6 - 8 - 10