Rooted Chiropractic
HEALTH . FAITH . RESULTS

Health Information Form

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Legal Name: _____ Today's Date: ____/____/____

If practice member is a minor, parents name(s): _____

Date of Birth: ___/___/___ Age: ____ Male/Female

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer's Name: _____

Single/ Married/ Divorced/ Widowed Spouse's Name: _____

Number of Children: ____ Names & Ages: _____

Emergency Contact: _____ Phone: _____

Who can we thank for referring you? _____

Have you previously been to a Chiropractor? Y/N Name of office: _____

Date of last chiropractic adjustment? _____Date of last spinal x-rays: _____

Health Concerns:

Health Concerns: In Order of Importance	Severity 1=Mild 10=Unbearable	How long have you had this?	Did this start with an injury?	Describe the pain ex: numbness, tingling, sharp, dull, achy, traveling
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____
5._____	_____	_____	_____	_____

****WOMEN ONLY**** *For x-ray purposes, is there any possibility that you could be pregnant? YES/NO*

If yes, how far along are you? _____ Due Date: _____

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?

_____

What are your health goals? How will they change your life once attained?

_____

What, if any, makes your number one complaint worse?

☐ Nothing ☐ Working ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Sleeping

If other, please explain:

_____

Have you seen anyone else for this health concern? (MD, PT, Chiro, etc.) If so, who and when?

_____

Please list all over the counter & prescription medications you take/ last round of antibiotics:

_____

_____

_____

Please list all traumas (broken bones, surgeries, auto accidents, hospitalizations) and when:

_____

_____

_____

_____

Social History: DO YOU…

SMOKE? Y / N HOW OFTEN? _____

EXERCISE? Y / N HOW OFTEN? _____ MILD / MODERATE /INTENSE

Notes:

Please check off any of the conditions below that you (or your family) have or have had in the past:

	Yourself	Spouse	Children	Mother	Father
Allergies					
Sinus					
TMJ/Jaw Pain					
Sleep Issues					
Fatigue					
Epilepsy					
Headaches					
Migraines					
Dizziness					
Vertigo					
Anxiety					
Nervousness					
Fainting					
Ear Infections					
Asthma					
Acid Reflux					
Irritable Bowel					
Stomach Condition					
Nausea					
Liver Disease					
Kidney Condition					
Abnormal Menstrual					
Ulcers					
Lupus					
Psoriasis					
Stiffness					
Numbness					
Disc Problems					
Arthritis					

INFORMED CONSENT

You have a right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

INTRODUCTION

Chiropractic is predicated on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nerve system) of the body and how this relationship can affect the restoration and preservation of health. The following information is routinely furnished to all who consider Chiropractic care and treatment in this clinic.

THE NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by Chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nerve system is vertebral subluxation. This condition is where one or more vertebra in the spine is misaligned sufficiently to cause interference and/or irritation to the nerve system. The primary goal in Chiropractic health care is the removal of nerve interference caused by subluxation.

A Chiropractic examination will be undergone which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays). The Chiropractic adjustment is the application of a precise, high velocity movement of the spine over a very short distance. There are several different methods or techniques by which Chiropractic adjustment is delivered. Chiropractic adjustments can be delivered by hand or by instrument at Rooted Chiropractic, depending on what is best for the patient.

CONSENT FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of Chiropractic care, the possible consequences of care, and the risks of care, including the risk that care may not accomplish the desired objective. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE ROOTED CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____ _____

Patient Signature **Date** **Witness Signature**

HIPAA Policy
This notice was published and becomes effective on/or before April 14, 2003
We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Financial Policy
We do our best to get your insurance coverage before coming into our office by contacting your insurance company. Please note this is NOT a guarantee of benefits. You must understand that we do not promise that an insurance company will reimburse this practice or you for the services rendered and ultimately in the event that an insurance company denies payment, it is the responsibility of you to pay the charges and seek reimbursement from your insurance company. It is your responsibility to let Rooted Chiropractic know if you insurance policy has changed. Account balances over 30 days will be charged to your credit card unless prior arrangements have been made.

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

WRITTEN CONSENT FOR A CHILD/MINOR

NAME OF PATIENT WHO IS A MINOR/CHILD: _____

I authorize the staff at Rooted Chiropractic 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 authorize care is revoked or altered, I will immediately notify Rooted Chiropractic.
Guardian's Relationship to Minor/Child_____

HAVING THIS KNOWLEDGE, BY SIGNING HERE I HAVE READ AND AGREE TO THE TERMS ABOVE

Signature: _____ **Date:** _____

_____ **Family Permission**
(initial)
I give permission for Rooted Chiropractic to talk to anyone listed on my forms about my care. If that preference was to change, it is my responsibility to let you know.

_____ **Model Release**
(initial)
For valuable consideration received, I hereby grant to Rooted Chiropractic the irrevocable and unrestricted right to use and publish photographs of me, or in which I may be included, for editorial trade, advertising, and any other purpose and in any manner and medium; and to alter the same without restriction. I hereby release the photographer and her legal representatives and assigns from all claims and liability relating to said photographs.

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.

COPIES OF YOUR X-RAYS WILL BE AVAILABLE FOR $15 ON CD-ROM.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

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. DR. GEORDON CARTER OF ROOTED CHIROPRACTIC 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. **BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____

PRINT YOUR NAME HERE **DATE**

_____ _____

SIGNATURE **AGE**

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

_____ _____

SIGNATURE **DATE**