SMITH CHIROPRACTIC HEALTH PROFILE

Today's Date:_____

Name:_____ Age:_____ Male/Female DOB:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Cell:_____ Cell Phone Provider: _____

SSN#: _____ Email Address:_____ Single/Married/Divorced/Widowed

Spouse's Name:_____ # of Children:_____ Names, Ages & Gender: _____

Occupation/Employer:_____ Emergency Contact/Phone#:_____

Primary Insurance Carrier:_____ Phone #:_____

Primary Policyholder Name:_____ Date of Birth: ____/____/____

Relationship to Patient:_____ Who may we thank for referring you? _____

What is your preferred contact method? Email/Text/Phone Call

LIST YOUR HEALTH CONCERNS BELOW

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

CIRCLE ALL PROBLEMS YOU CURRENTLY HAVE:

Headaches	Convulsions/Epilepsy	Heartburn	Foot or Knee Problems
Neck Pain	Allergies	Digestive Problems	Skin Problems
Sinus Problems	Jaw Pain/TMJ	Low Back Pain	Loss of Balance
Double/Blurred Vision	Numb/Tingling arms, hands, fingers	Numb/Tingling legs, feet, toes	Swollen Joints
Ringing in Ears	Upper Back Pain	Hip Pain	Fainting
Hearing Loss	Shoulder Pain	Prostate Problems	Depression
Tremors	Chest Pain	Sexual Dysfunction	Trouble Sleeping
Dizziness	Asthma	Menstrual Problems	ADD/ADHD
Frequent Colds/Flu	Mid Back Pain	Bed Wetting	Mood Changes

CIRCLE ANY CONDITION YOU HAVE NOW/HAVE HAD:

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

Are you currently pregnant? YES NO

LIST ALL SURGICAL OPERATIONS AND YEARS_____

LIST ALL over the counter & prescription medications you are on:

_____

Have you ever been under chiropractic care? YES NO If yes, Doctor Name & Date_____

Have you ever been knocked unconscious? YES NO Fractured a bone? YES NO

Have you ever been in a serious auto accident? YES NO

If yes, please describe_____

Other trauma_____

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

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. **THE FEE FOR COPYING YOUR X-RAYS IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.**

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. THE DOCTORS OF SMITH 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

_____ _____

SIGNATURE YOUR AGE

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

SIGNATURE_____ DATE_____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE 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

When a patient seeks chiropractic health care we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, 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.

We do not offer to diagnose or treat any disease 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 a health care provider who specializes in that area.

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 innate wisdom. Our only method is adjusting to correct vertebral subluxations.

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, texts or health information to me as an extension of my care in this office.

I grant permission for the staff to use photographs/images, testimonials and quotations from me. These can be displayed around the office and on social media.

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

I, _____ understand 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 DATE

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 points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by laws 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 the 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 the 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 across 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 of specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with 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 through 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.

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.

_____ _____

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 (HIPPA). 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 privacy 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 private information is used to disclose to 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