GLOBAL HEALTH CHIROPRACTIC

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Age: _____ Gender: ☐ M ☐ F

Home Address: _____ Home Phone: (_____) _____

City, State, Zip: _____ Work Phone: (_____) _____

Email Address: _____ Cell Phone: (_____) _____

Birth Date: _____ / _____ / _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _____ Employer Name: _____

Names of Children: _____ Ages: _____

Spouse's Name: _____ Cell Phone: (_____) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE FOR THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _____

When did this condition begin? _____ / _____ / _____ Did it begin: ☐ Gradual ☐ Sudden ☐ Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Type of pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb ☐ Tingling ☐ Shooting

Does the pain radiate into your: ☐ Arm ☐ Leg ☐ Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10% ☐ Only with activity

Does complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take x-rays? ☐ Yes ☐ No Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? ☐ Yes ☐ No

If YES, does that concern you? ☐ Yes ☐ No

HEALTHY LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X per week ☐ other: _____

What activities? ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Gym Membership

Do you smoke? ☐ Yes ☐ No ☐ How much? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ How much / week? _____

Do you drink coffee? ☐ Yes ☐ No ☐ How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Do you drink filtered/ bottled water? ☐ Yes ☐ No Do you purchase organic/ locally grown food? ☐ Yes ☐ No

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). **Please check any health condition you may be experiencing, now or in the past.**

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking

Explain: _____

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness Of Breath
- ☐ Pain On Deep Inspiration/Expiration

THORACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/ chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ☐ Mid Back Pain
- ☐ Pain Into Your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Tired/Irritable after eating or when you haven't eaten for a while
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/ feet and pelvic organs and affect these parts of your body. Do you experience…?

- ☐ Pain into your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Constipation / Diarrhea
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction

Please list any **health conditions** not mentioned: _____

Please list any **medications** currently taking and their purpose: _____

Please list all past **surgeries**: _____

Please list all previous **accidents and falls**: _____

GOAL FOR MY CARE

Indicate all statements that apply to you:

- ☐ I have a specific health concern.
- ☐ I want to ensure that my health concerns do not become an ongoing problem.
- ☐ I am interested in learning how to improve my quality of life.

Are you healthier now than you were 1 year ago? ☐ Yes ☐ No

If yes, what did you do to accomplish this? _____

Is it your goal to be healthier 1 year from now than you are today? ☐ Yes ☐ No

Do you have a plan on improving your health? _____

Have you ever been advised on lifestyle choices for good health? ☐ Yes ☐ No

TERMS OF ACCEPTANCE

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Global Health Chiropractic, I give authorization to proceed with any treatment the doctor(s) deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

MISSED APPOINTMENTS

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

CONSENT TO EVALUATE AND TREAT A MINOR

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.

COMMUNICATIONS

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Children: _____

Others: _____ ☐ No one

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? ☐ Yes ☐ No

ACKNOWLEDGEMENT

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Signature: _____ Date: _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through the use of spinal adjustments, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Global Health Chiropractic, LLC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Global Health Chiropractic, LLC will be credited to my account on receipt.

Patient or Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Signature: _____ Date: _____