



Your Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

E-mail _____

Birthdate _____ Gender _____

Marital Status _____

Social Security # _____

Occupation _____

Employer _____

Work Address _____

Work Phone # _____

Spouse's Name _____

Do you have children? _____

Insurance Co Name _____

Insurance ID# _____

Other Insurance Co Name _____

Other Insurance ID# _____

Person responsible for this account _____

Relationship to you _____

Billing Address _____

Billing Phone # _____

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and/or your spouse checked for subluxations, **check the box below. They each can receive a complementary exam, including computerized surface EMG, if scheduled within 2 weeks of your start of care.** This exam is at no cost to you and it does not obligate him/her to receive treatment. Should your family members decide to receive care, we do have several convenient, affordable family plan payment options available.

I would like my family member(s) checked for subluxations within the next 2 weeks.

Do you have (or have you had) any of the following?

Mark all that apply to you.

- ___ Frequent/severe headaches
- ___ Inability to concentrate
- ___ Difficulty with night vision
- ___ Difficulty focusing on small objects
- ___ Ringing in the ears
- ___ Inability to adapt to loud sounds
- ___ Fainting/epilepsy/seizures
- ___ Problems with balance
- ___ Coordination problems
- ___ Shortness of breath
- ___ Loss of sense of smell
- ___ Over or under-production of saliva
- ___ Under/over productive thyroid
- ___ Vocal cord issues
- ___ Ear, nose, throat, sinus infections
- ___ High or low blood pressure
- ___ Lung infections/pneumonia
- ___ Abnormally Fast or slow pulse
- ___ Heart problems/heart attack/stroke
- ___ Stomach issues/ulcers/reflux/indigestion
- ___ Pancreas/diabetes/high or low blood sugar
- ___ Sleepy after meals
- ___ Liver issues
- ___ Anemia
- ___ Gallstones
- ___ Intestinal issues
- ___ Appendicitis
- ___ Adrenal fatigue/exhaustion
- ___ Kidney stones
- ___ Frequent diarrhea/constipation
- ___ Less than 2 bowel movements/day
- ___ Colitis/diverticulitis/colon cancer
- ___ Male/female disorders
- ___ Difficulty getting pregnant
- ___ Urinary or bowel incontinence
- ___ Cancer
- ___ HIV/AIDS

Are you taking any medications? _____ YES _____ NO

(Include the following: nerve pills, pain relievers, aspirin, muscle relaxers, Motrin/ibuprofen/Advil/Aleve, Tylenol, insulin, blood thinners, stimulants, tranquilizers, BETA blockers, diuretics, other)

What are you taking? _____

Please list any surgeries and the dates.

Please list any previous accidents and the dates.

Do you take vitamins? _____ Do you smoke? _____ Do you wear orthotics or heel lifts? _____
How long have you had your mattress? _____ Is it comfortable? _____
Are you pregnant? _____ Are you nursing? _____

List the pains/complaints/condition for which you have come to seek help today. List them in order of most severe to least severe.

1. _____ 2. _____
3. _____ 4. _____

For the following questions, please mark all that apply:

In what ways have you taken care of your health in the past?

____ Medications _____ emergency room _____ routine medical _____ exercise _____ vitamins
____ Nutrition/diet holistic care _____ chiropractic other _____

How effective were the methods you used?

Poor _____ fair _____ good _____ great _____ no change _____ temporary improvement _____ condition worsened _____

Have the other people in your life been affected by your health condition/concerns? _____

If so, in what way(s)? _____

Are you concerned your health condition has or might affect any of the following?

Job _____ kids _____ marriage _____ independence _____ time _____ finances _____ self-esteem _____ sleep _____

Do you have concerns that your current condition might develop into any of the following?

Heart disease _____ cancer _____ diabetes _____ arthritis _____ fibromyalgia _____ depression _____ fatigue _____ surgery _____

What is your greatest concern regarding your condition? _____

Where do you picture yourself being in 2 years if this problem persists? _____

What would be better or different without this problem? _____

What results do you most desire from working with us? _____

If those results were able to be achieved, what would that be worth to you? _____





ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that as a patient I have received, reviewed and understand the Hood Chiropractic Notice of Privacy Practices.

Patient's Printed Name _____
(Please Print)

I understand that I have the right to:

- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I have read, reviewed and been offered to receive a copy of the Practice's Notice of Hood Chiropractic and understand that my protected health information may be used by the office as described in the notice.

Signature of Patient _____ Date: _____
(or Personal Representative)

Name of personal Representative _____
Relation to patient _____

Please note the Personal Representative is the patient's decision maker if the patient cannot act for himself or herself. It can be the parent, legal guardian, health care surrogate, or other named individual.

Consent of Release of Protected Health Information

I acknowledge and give permission to _____ to have access to the following: _____
(Please Print)

Check items you give permission to this individual for
 Pick up in the office paperwork or medical records
 Release information about test or radiology results results
 Release information about my account status
 Release information about appointments, missed visits, coordination of care with other physicians, lab results, accounts receivable, educational materials or any other items related to the continuation, coordination or item related to your healthcare treatment in the office.

Signature of Patient _____ Date: _____
(or Personal Representative)

Witnessed by staff _____ Date: _____



TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent 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 adjustments of the spine.

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

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

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic 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 that 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 specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction.

(Signature)

(Date)

Consent to Treatment of Minor Child

I hereby authorize Hood Family Chiropractic Center to administer treatment as they so deem necessary to my daughter / son / other,

_____ (name)

Date: _____

Signed: _____

Witness: _____