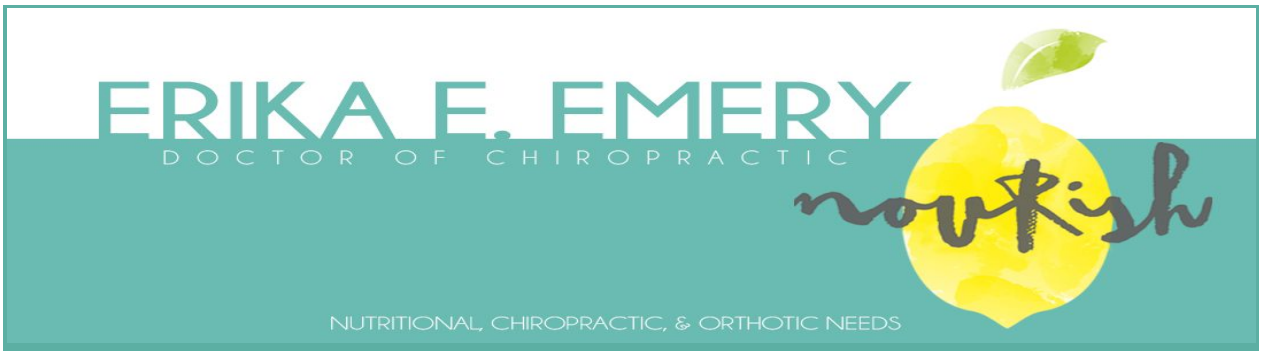


Date: _____

PERSONAL INFORMATION

First Name: _____ M.I. _____ Last Name _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Email: _____

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

Number Of Children: _____

Children's Names & Age: _____

Who can we thank for referring you or how did you hear about Nourish Chiropractic?

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Nourish Chiropractic?

_____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

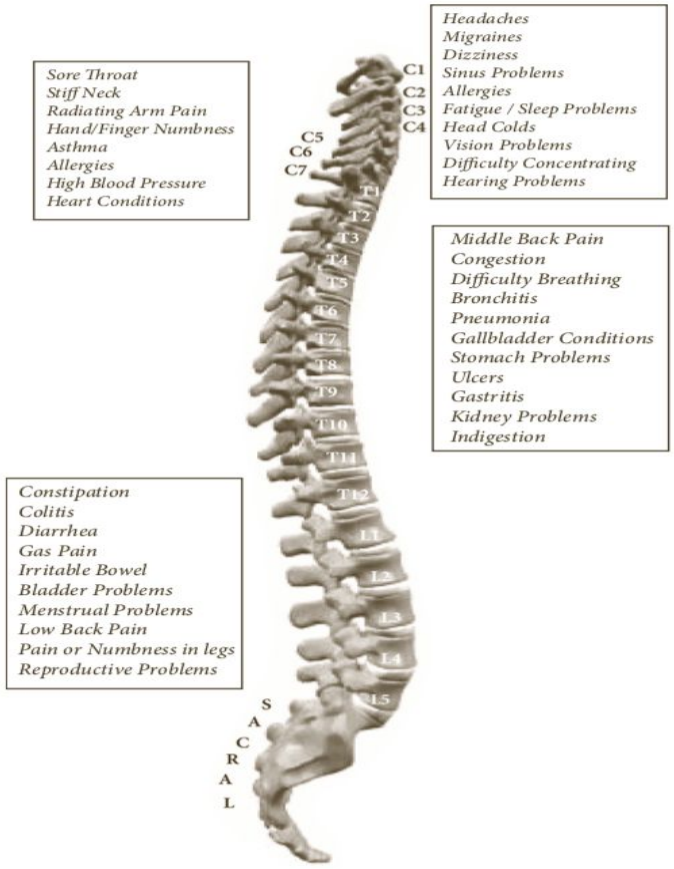
_____

_____

HEALTH CONCERNS

- ❑ Anxiety/Depression
- ❑ Digestive Troubles
- ❑ Nausea/Vomiting
- ❑ Diabetes
- ❑ Hypertension
- ❑ Arthritis
- ❑ Loss of Balance
- ❑ Neck/Back Pain
- ❑ Pain in Arms/Legs
- ❑ Irritability
- ❑ Fatigue/Sleep Issues
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Sensitivity to Light
- ❑ Loss of Concentration
- ❑ Memory Problems
- ❑ Headaches
- ❑ Stiffness/Flexibility
- ❑ Sinus Troubles/Allergies
- ❑ Cold Hands/Feet
- ❑ Other

_____



Explain any boxes checked above or add additional concerns:
_____
_____
_____
_____

Is there anything else regarding your current condition you feel the doctor should know? _____
_____
_____

MEDICATIONS

- ❑ Anxiety/Depression
- ❑ Blood Pressure
- ❑ Pain Narcotics
- ❑ Muscle Relaxers
- ❑ Migraine/Headache
- ❑ Cholesterol
- ❑ ADD/ADHD
- ❑ Diabetes
- ❑ Other _____

- ❑ Other _____

- ❑ Other _____

Explain any boxes checked above: _____

_____

VITAMINS/SUPPLEMENTS

- ❑ Multi-Vitamin
- ❑ Vitamin D3
- ❑ Fish Oil/Omega-3
- ❑ Probiotics
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Explain any boxes checked above:
_____

STRESS QUESTIONNAIRE

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.

Please check any of the following stresses you experience on a regular basis.

Physical Stress

- ❏ Physical pain
- ❏ Low Energy/Fatigue
- ❏ Job/Hobbies Causing Discomfort
- ❏ Tightness/Stiffness
- ❏ History of Accidents/Injuries
- ❏ Inability to Exercise/Perform Physical Activities
- ❏ Other _____

Explain: _____

Chemical Stress

- ❏ Fast Food/HIghly Processed Food
- ❏ Medications (Prescriptions or OTC)
- ❏ Consume Alcohol
- ❏ Tobacco
- ❏ Makeup/Lotion/Other Skin Products
- ❏ Other _____
- ❏ Explain:

_____

Emotional Stress

- ❏ Work/Job
- ❏ School
- ❏ Family
- ❏ Finances
- ❏ Daily Schedule/Time
- ❏ Other _____

Explain: _____

_____

_____

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: _____ Last Name: _____

Address: _____

City / State / Zip: _____ Phone: ( ) _____

Relation: _____

X-RAY CONSENT

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which Nourish Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed:_____ Date:_____

X-Ray Consent for Women Childbearing Age

This is to certify that, to the best of my knowledge, I am not pregnant, and Nourish Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis can be hazardous to my unborn child.

Signed:_____ Date:_____

For Office Use Only

ID#_____

Films:_____

ROF:_____

Other:_____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, pubic 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 within 30 days with a request. You may request to view charges 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 and Accountability Act of 1996 (HIPAA), 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, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.*

Date:_____ Print Patient Name:_____

Signature:_____
_

AUTHORIZATION FOR CARE

I hereby authorize the doctor and staff at Nourish Chiropractic to treat my condition as deemed. At Nourish Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any staff member of Nourish Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you. Date: _____

Signature: _____

ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: _____

Name(Printed):_____

Signature:_____

Parent/Guardian Signature (if applicable): _____