



Discover Chiropractic

...an extraordinary chiropractic experience

Today's Date: _____

1. **PAPER FUN**...to help us get to know you, your lifestyle and health history...to customize a care plan that is a solution for your health, personal needs, wants, and life.
2. **EXAMINATION**...focused on identifying the CAUSE of interferences and disturbances that have led to your reason for being here today and how they influence your function, adaptability, health, and lifestyle.
3. **SOLUTIONS**...On your second visit we'll review your findings and let you know if we can help.

Name: _____ Birth Date: _____ Age: _____ Sex: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Business Phone: _____ Cell #: _____
 E-Mail Address: _____ Social Security Number: _____
 Employer: _____ Occupation: _____ Married Single Widowed Divorced
 Name of Spouse: _____ Spouse's Employer: _____
 Names and Ages of your children: _____

Name and Phone # of Emergency Contact: _____ Relationship: _____
 Who referred you to our office? _____

Who is responsible for your bill: Self Spouse Parent Workman's Comp. Auto Insurance Medicare
 Insurance Carrier _____ ID _____ Provider # _____

What is your primary complaint? (Please be SPECIFIC): _____

Please check reasons for pursuing chiropractic care:

- I'm continuing ongoing care from another chiropractor.
- I'm interested in wellness and natural health care.
- I'm concerned about my health and I'm looking for answers.
- I have no idea why I'm here. Please take the time to explain to me what you do.

TYPE OF CARE

People visit the Chiropractor for a variety of reasons. Some go for symptomatic relief of pain or discomfort. This is called **Relief Care**. Others are interested in having the cause of the problem as well as the symptoms corrected and relieved. This is called **Corrective Care**. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care. This is called **Comprehensive Care**. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes when possible.

- Relief Corrective Comprehensive Doctor to Select

HISTORY OF YOUR CONDITON

What is the reason for your visit? (please be specific) _____

Have you suffered with this before or a similar problem in the past? Yes No If yes how many times? ____

When was the last episode? _____ How did the injury happen? _____

Place an X where you feel pain, numbness or tingling.

HOW DOES YOUR CONDITION AFFECT YOUR LIFE

What is the AVERAGE level of the problem you experience in a typical day?

Completely able to function Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

What is the LOWEST level of the problem you experience in a typical day?

Completely able to function Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

What is the HIGHEST level of the problem you experience in a typical day?

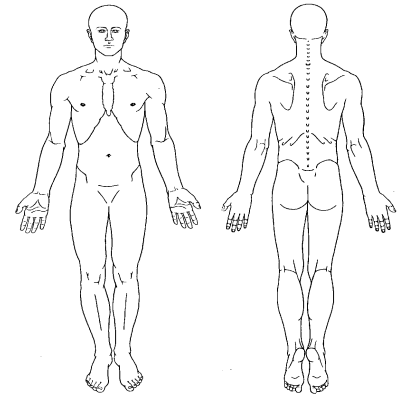
Completely able to function Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

When you have the problem what percent of the day is it present?

Completely able to function Totally unable to function

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



How many days a week do you have the problem? 0 1 2 3 4 5 6 7

Is it worse in the: Morning Afternoon Evening Night Other _____

Overall, is your condition: Staying the same Getting better Getting worse

How does it interfere with your activities?: Annoyance Tolerable Significant Complete

What aggravates this condition?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Anger | <input type="checkbox"/> Carrying | <input type="checkbox"/> Emotional Upset |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Standing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Reclining | <input type="checkbox"/> Stooping | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Repetitive Movement | <input type="checkbox"/> Straining at Toilet | <input type="checkbox"/> Throwing | <input type="checkbox"/> In/Out of Bed |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Stress | <input type="checkbox"/> Turn Head left | <input type="checkbox"/> In/Out of Car |
| <input type="checkbox"/> Rising From Chair | <input type="checkbox"/> Swimming | <input type="checkbox"/> Turn Head Right | |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Climbing Ladder | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Walking Up Hill | |

Does this cause:

- Moodiness
- Irritability
- Interrupted Sleep
- Restricted Activities

Does this affect your work:

- Decision Making
- Poor Attitude
- Decreased Productivity
- Exhausted At End Of Day
- Unable To Work Long Hours

Does this affect your life:

- Lose Patience With Spouse Or Children
- Restricted Household Duties
- Affects Ability to Exercise Or Participate In Sports
- Interferes With Ability To Participate In Hobbies Or Other Desired Activities

What makes your condition feel better?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Resting | <input type="checkbox"/> Elevation | <input type="checkbox"/> Chiropractic Adjustments |
| <input type="checkbox"/> Rubbing Heat Liniment | <input type="checkbox"/> Exercising | <input type="checkbox"/> Tylenol/ Advil |
| <input type="checkbox"/> Rubbing Mineral Ice | <input type="checkbox"/> Reclining | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Pain Pills | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Bending | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Hot Showers | |

For this condition have you ever sought the services of:

- | | | | | |
|--|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Massage | <input type="checkbox"/> Naturopath | <input type="checkbox"/> Yoga Studio | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Homeopath | <input type="checkbox"/> Physical Trainer | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychiatrist |

PERSONAL HEALTH PROFILE

Do you currently:

- | | |
|--|--|
| <input type="checkbox"/> Exercise... ____ / Week | <input type="checkbox"/> Take Supplements / herbs / vitamins |
| <input type="checkbox"/> Smoke... ____ / Day | <input type="checkbox"/> Drink Alcohol |
| <input type="checkbox"/> Drink Coffee | Other _____ |

Do you have any other medical condition other than that which you are now consulting us? Yes No

(if yes explain): _____

What **NON-PRESCRIPTION(s)** are you taking? _____

What **PRESCRIPTION(s)** are you taking? _____

Have you or any family members previously had chiropractic care? Yes No

Frequency of visits: ____ times a week month Duration of care: ____ weeks months

Have you or do any members of your family had/have: Heart Trouble High Blood Pressure Diabetes

Arthritis Back Problems Cancer Other: _____

Have you been told you have spinal curvature, spinal arthritis, or inherited spinal conditions? Yes No

How would you rate your health: Never felt worse - 1 2 3 4 5 6 7 8 9 10 - Feel great!

Are you healthier than you were 5 years ago? Yes No

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of this problem. _____/10

Please check any of the conditions you have suffered from in the last 6 months.

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nervous Stomach |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Other Stomach Problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Pancreas Problems |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Immune Problems |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Chronic/Frequent Colds | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Chronic/Frequent Flu | <input type="checkbox"/> Chronic/Frequent Flu |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Chronic/Frequent Fever |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Adrenal Gland Problems |
| <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Spleen Issues |
| <input type="checkbox"/> Chronic Tiredness | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Vision Disturbances | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Issues With Tonsils | <input type="checkbox"/> Eczema Or Dry Skin |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Ear Ache | <input type="checkbox"/> Pain In Your Hips/Legs/Feet |
| <input type="checkbox"/> Shoulder/Arm Pain | <input type="checkbox"/> Numbness/Tingling In Your Legs/Feet |
| <input type="checkbox"/> Shoulder/Arm Tingling | <input type="checkbox"/> Coldness In Your Legs/Feet |
| <input type="checkbox"/> Shoulder/Arm Numbness | <input type="checkbox"/> Cramps In Legs/Feet |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Weakness/Injuries In Your Hips/Legs/Ankles |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Poor Circulation In The Legs |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Weak Ankles & Arches |
| <input type="checkbox"/> Pain Wrist/Hand/Finger | <input type="checkbox"/> Weakness In Legs |
| <input type="checkbox"/> Tingling Wrist/Hand/Finger | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Numbness Wrist/Hand/Finger | <input type="checkbox"/> Bladder Troubles |
| <input type="checkbox"/> Weakness In Arm Or Hand | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Painful Periods |
| <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Irregular Periods |
| <input type="checkbox"/> Pain On Deep Breathing | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Painful Or Frequent Urination |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Gall Bladder Conditions | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Liver Conditions | <input type="checkbox"/> Sacro-Iliac Conditions |

- Spinal Curvatures
- Scoliosis
- Pain At The End Of The Spine when Sitting

Was your birth:

- Forceps or Suction
- Cord around the neck
- Drug induced
- "C" section
- Breech

Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision?

- Automobile/Bus
- Motorcycle/ Moped/ bicycle
- Train/ Airplane
- Other vehicles: _____

Work Posture: (during the day)

- Sit
- Stand
- Walk
- Do desk work
- Phone work
- Drive
- Heavy lifting
- Do mechanical work

Have you ever had a fall, even if you think you were not hurt:

- From a crib/bed
- Stroller
- Down or up steps/stairs
- Chair pulled out from under

Health Care Procedures: Have you ever had a:

- Spinal Injection
- Spinal Tap Work
- Extensive Dental Work
- Ever On Crutches
- Bifocals
- Heel Lifts
- Corrective shoes or bars on shoes
- Neck Collar
- Ever used a walker/cane
- Body part in a cast or immobilized

Physical Traumas:

- Physical fight
- Banged your head
- Play a musical instrument
- Particular position for watching TV
- Sports
- Had a Broken Bone
- Been knocked unconscious?
- Bad Jolt or Impact
- Dislocations
- Read for prolonged period

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

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

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Discover Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ *Initials*

REGARDING: X-Rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ *Initials*

NOTICE OF PRIVACY PRACTICES

I have received a copy of Discover Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

***Authorization for Use and Disclosure of Health Information Type of information to be released:
Video images, photographic images, verbal and/or written testimonials and statements.***

Patient signature

Date

OUR OFFICE POLICIES

WELCOME TO DISCOVER CHIROPRACTIC

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there are no misunderstandings as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Discover Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors [use 1 \)Spinal Manipulation OR 2\) a myriad](#) of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through [two](#) distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and Discover Chiropractic retains the signature sheet.

Discover Chiropractic Notice Of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our office at 408-985-1111. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201