Patient Health History

Date	I.D. #

Name: _____ Age: _____ Date of Birth: _____ Sex: ❑M❑F

Address: _____ City: _____ State: ____ Zip: _____

Phone (Home): _____ (Work): _____ (Cell): _____ (Fax): _____

Email Address: _____ Marital Status: ❑S ❑M ❑D ❑W Number of Children: _____

I give you permission to email me appointment reminders, special offers, newsletters, birthday cards, etc. ❑Yes ❑No

Occupation: _____ Social Security Number: _____

Employer: _____ Driver's License Number: _____

Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Phone (Work): _____

Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____

Insurance Company: _____ Spouse's Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Past Chiropractic Care: ❑Yes ❑No When? _____ Chiropractic Doctor's Name: _____ Results: _____

Medical Doctor's Name: _____ I give you permission to send my Medical Doctor a report regarding my chiropractic care. ❑Yes ❑No

I give you permission to place my name on the referral board or computer screens in the office for referring patients to this office. Thank you in advance. ❑Yes ❑No

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Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other: _____

Are you now or have you ever been disabled? (Service or Work)? ❑Yes ❑No When? _____

Have you retained an attorney? ❑Yes ❑No Name & Address: _____

What is your current work status?

❑Full time, no restrictions ❑Full time, restrictions ❑Full time Homemaker ❑Full time student

❑Part time, no restrictions ❑Part time, restrictions ❑Retired ❑Unemployed

❑Off work due to restrictions ❑Other _____

Restrictions:

Off work: ❑Yes ❑No ❑Previously From: _____ to _____

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____

Do/did you require outside help at home?

❑Yes ❑No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: ❑Auto: _____ ❑Recreation: _____

❑Sports: _____ ❑Work Related: _____ ❑Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ❑Yes ❑No Why? _____

Were you ever knocked unconscious? ❑Yes ❑No (If yes, please explain): _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ❑Yes ❑No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

(Please list) _____

OPERATIONS AND PROCEDURES

❑ I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other _____

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑Never ❑Previously ❑Presently

Never	Previously	Presently	GENERAL SYMPTOMS
❑	❑	❑	Allergy(What) ____
❑	❑	❑	Bronchitis
❑	❑	❑	Chills (Constant)
❑	❑	❑	Convulsions
❑	❑	❑	Dizziness
❑	❑	❑	Fainting
❑	❑	❑	Fatigue
❑	❑	❑	Headache
❑	❑	❑	Loss of Sleep
❑	❑	❑	Loss of Weight
❑	❑	❑	Nervousness
❑	❑	❑	Night Sweats
❑	❑	❑	Numbness or Pain in arms/legs/hands
❑	❑	❑	Wheezing

MUSCLES & JOINTS

❑	❑	❑	Backache
❑	❑	❑	Foot Trouble
❑	❑	❑	Hernia
❑	❑	❑	Pain Between Shoulders
❑	❑	❑	Painful Tail Bone
❑	❑	❑	Stiff Neck
❑	❑	❑	Spinal Curvature
❑	❑	❑	Swollen Joints
❑	❑	❑	Tremors
❑	❑	❑	Twitching

Never	Previously	Presently	GASTRO-INTESTINAL
❑	❑	❑	Belching or Gas
❑	❑	❑	Colon Trouble
❑	❑	❑	Constipation
❑	❑	❑	Diarrhea
❑	❑	❑	Gall Bladder Trouble
❑	❑	❑	Hemorrhoids (piles)
❑	❑	❑	Jaundice
❑	❑	❑	Liver Trouble
❑	❑	❑	Nausea
❑	❑	❑	Stomach Pain
❑	❑	❑	Vomiting
❑	❑	❑	Vomiting Blood
❑	❑	❑	Heart Burn
❑	❑	❑	Bloody Stools
❑	❑	❑	Acid Reflux
❑	❑	❑	Irritable Bowel

CARDIO-VASCULAR

❑	❑	❑	High Blood Pressure
❑	❑	❑	Low Blood Pressure
❑	❑	❑	Chest Pain
❑	❑	❑	Heart Trouble
❑	❑	❑	Poor Circulation
❑	❑	❑	Rapid Heart
❑	❑	❑	Slow Heart
❑	❑	❑	Strokes
❑	❑	❑	Swelling Ankles
❑	❑	❑	Varicose Veins

Never	Previously	Presently	EYE/EAR NOSE/THROAT
❑	❑	❑	Asthma
❑	❑	❑	Deafness
❑	❑	❑	Earache
❑	❑	❑	Ear Discharge
❑	❑	❑	Ear Noises
❑	❑	❑	Thyroid Problems
❑	❑	❑	Frequent Colds
❑	❑	❑	Hay Fever
❑	❑	❑	Nasal Obstruction
❑	❑	❑	Nose Bleeds
❑	❑	❑	Pain in Eyes
❑	❑	❑	Poor Vision
❑	❑	❑	Blurred Vision
❑	❑	❑	Sinusitis
❑	❑	❑	Sore Throats
❑	❑	❑	Tonsillitis

SKIN OR ALLERGIES

❑	❑	❑	Bruising Easily
❑	❑	❑	Dryness
❑	❑	❑	Eczema
❑	❑	❑	Hives or Allergy
❑	❑	❑	Itching
❑	❑	❑	Sensitive Skin
❑	❑	❑	Skin Eruptions

Never	Previously	Presently	RESPIRATORY
❑	❑	❑	Chest Pain
❑	❑	❑	Chronic Cough
❑	❑	❑	Difficulty Breathing
❑	❑	❑	Spitting Blood
❑	❑	❑	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	Bed Wetting
❑	❑	❑	Blood in Urine
❑	❑	❑	Frequent Urination
❑	❑	❑	Inability to Control Urine
❑	❑	❑	Kidney Infection
❑	❑	❑	Kidney Stones
❑	❑	❑	Painful Urination
❑	❑	❑	Prostate Trouble

FOR FEMALES ONLY

❑	❑	❑	Cramps
❑	❑	❑	Hot Flashes
❑	❑	❑	Irregular Cycle
❑	❑	❑	Painful Periods
❑	❑	❑	Vaginal Discharge

❑Yes ❑No Pregnant at this Time

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

HABITS

❑Smoking	Packs/day: _____
❑Drinking	Alcohol: (Cups/day) _____
❑Coffee	Cups/Day: _____
❑Soft Drink	Bottles or Cans/Day: _____
❑Water	Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back	Heart
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother(s), # of_____	❑	❑	❑	❑	❑
Sister(s), # of _____	❑	❑	❑	❑	❑

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider *will/will not* prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payors and to secure the payment of benefits.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

CURRENT COMPLAINT HISTORY
(PATIENT)

Patient Name: _____ **Date:** _____

Please check all boxes that apply to your condition **and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.**

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
2. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
3. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your **symptoms begin?**

❑Immediately after a specific incident ❑After multiple Incidents ❑Gradually developed over time ❑Other _____

What makes your **symptoms better?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your **symptoms worse?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

Are your **symptoms?**

❑Decreasing ❑Increasing
❑Not Changing ❑Other _____

Description of pain or symptoms:

❑Sharp ❑Shooting
❑Dull ❑Burning
❑Ache ❑Numb/Tingling
❑Weakness ❑Stiff
❑Throbbing ❑Other_____

Does your pain **move** or **radiate?**

❑Yes ❑No Where _____

Check the best and worse **times of the day** for your **pain:**

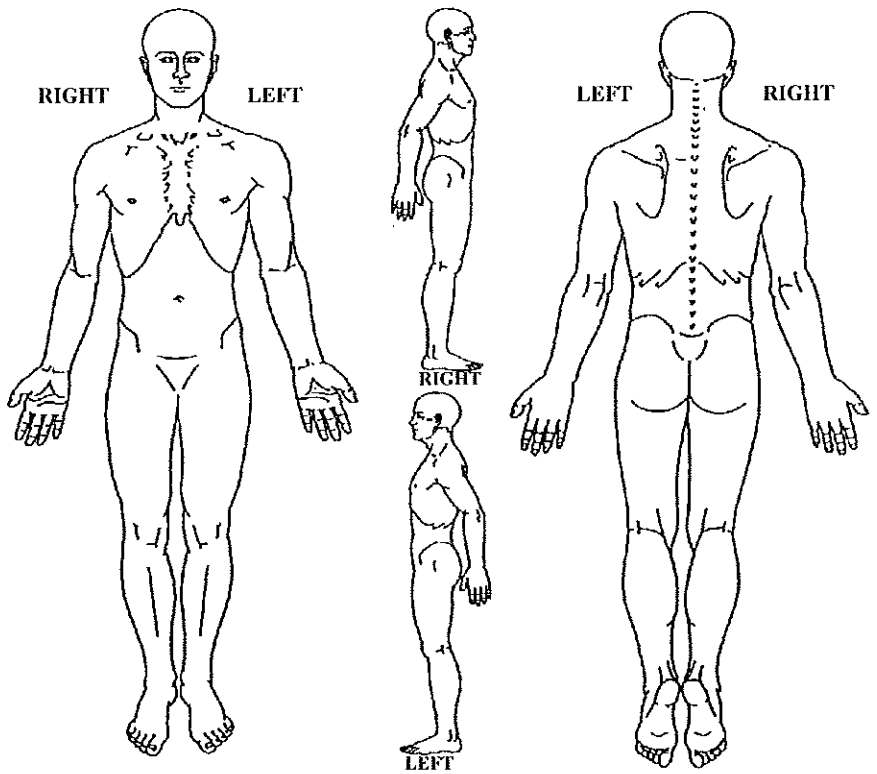
Best	Worst
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

Frequency of pain or symptoms:

❑Constant (76 – 100%)
❑Frequent (51 – 75%)
❑Occasional (26 – 50%)
❑Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES
S = STABBING X = STIFFNESS T = THROBBING O = OTHER



How many days out of **an average week** are you in **pain?** (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain?**

❑less than 1 hour ❑1 to 6 hours ❑6 to 12 hours ❑12 to 18 hours ❑18 to 24 hours ❑24 hours

Patient's/Guardian's Signature: _____ **Date:** _____

Discover Chiropractic Center, PC 6740 Cascade Road SE Suite 6 Grand Rapids, MI 49546 Phone: (616) 956-1112 Fax: (616) 956-6265 Web: www.dchiro.com

DISCOVER CHIROPRACTIC CENTER, PC
6740 Cascade Road Ste. 6
Grand Rapids, MI. 49546
P: 616.956.1112

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Discover Chiropractic, or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

DISCOVER
CHIROPRACTIC
& SOFT TISSUE CLINIC

"CONSENT FOR CARE"

INFORMED CONSENT FOR CHIROPRACTIC CARE

I, the patient, in coming to the doctor of chiropractic, give the doctor permission and authority to examine and care for me consistent with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render them susceptible to injury. Even though a procedure was performed correctly, I understand the doctor cannot guarantee results, and that I face risks that include, but may not be limited to: injury, fractures, disc injuries, paralysis, strokes, dislocation, strains/sprains or death that may occur from any procedure performed. By signing this consent for care form, I acknowledge the risk or danger and choose to have chiropractic and other procedures performed. The doctor will not give a chiropractic adjustment, or other health care procedure, if he/she is aware that such care may be contraindicated. Again, it is my responsibility to advise the doctor or to learn through health care procedures any condition from which I am suffering: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. I must look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not medical specialists. I understand that I must be aware of my own symptoms and conditions and I should secure other opinions if I have any concern as to the nature of my total condition.

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, and traditional medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

TREATMENT

I understand that I may receive any of the following treatments. Each will be explained in advance, and if you have any questions I will ask the doctor or staff before any procedure or treatment is performed. Treatments may include but are not limited to: chiropractic adjustments, extremity manipulation, Active Release Techniques® (ART®) Soft Tissue Treatment, Instrument Adhesion Release™ (IAR™), Manual Adhesion Release™, (MAR™), myofascial release, massage therapy, mechanical traction, spinal decompression traction therapy, rehabilitative exercises, nutritional counseling, cryotherapy, and heat pack therapy.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is immediate. In other cases it is gradual. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same procedures or treatments. Many medical failures find quick relief through chiropractic. Some conditions, which do not respond to chiropractic care, may come under the control of or be helped through medical science. I understand that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems.

TO THE PATIENT

Please discuss any questions or concerns with the doctor before signing this statement of consent.

I have read and understand the foregoing, and give my consent to proceed with chiropractic care.

*** When the patient is a minor, this form will be signed by the parent, legal guardian or person holding valid Delegation of Parental Rights for the minor. In the case, "I", "me" and similar words means the minor on whose behalf this form is signed.**

DATE	PATIENT SIGNATURE	PATIENT PRINT NAME

DATE	WITNESS

Discover Chiropractic Center, PC 6740 Cascade Road SE Suite 6 Grand Rapids, MI 49546 Phone: (616) 956-1112 Fax: (616) 956-6265 Web: www.dchiro.com

Discover Chiropractic Center, P.C.
Office Policies

Thank you for choosing Discover Chiropractic Center, P.C. ("Discover") as your Chiropractic Health Care provider. We are committed to providing you with the best care possible.

Any X-rays taken at this office will remain the permanent physical property of this office for a minimum of seven years. Copies of the patient's X-rays and/or records will be provided when a minimum advance notice of two working days is given. We reserve the right to charge a "copying" fee for the reproduction of the above X-rays and/or records.

If you do not have health insurance or your health insurance does not cover chiropractic services, massage, or any other service provided in this clinic, you agree to be fully responsible for payment of services rendered by Dr. Eric Lambert, DC and/or Discover Chiropractic Center, PC.

Payment will be made at time of service. We accept cash, check, Visa, MasterCard, & Discover. If we have to sent you an invoice for payment a $5 service fee will be added to the invoice.

Missed Appointments Policy:

All appointments are reserved especially for you (the patient). Therefore, please be considerate of other patients, and our office staff and **kindly give at least 24 hours notice** if you are unable to make your appointment. **We reserve the right to charge you for canceled or missed appointments.** If broken appointments become habitual, you may be dismissed from care.

Missed massage appointments will be charged full price for massage if a 24 hour notice is not given.

Initial _____

Financial Policy

Insurance & Billing:

1. As a courtesy to you, we accept most major insurance companies and we will submit claims to your insurance carrier. However, we are unable to bill your insurance unless you give us all your insurance information. This courtesy may be withdrawn if circumstances warrant it.

2. If you discontinue your care, your account is immediately due and payable in full, even if an insurance claim has been filed. (If the insurance company does send us payment, the payment will be applied to your account. When your account is paid in full, the balance will be refunded to you.)

3. We will bill your insurance at least monthly during active care at this office.

4. Our office does not guarantee that your insurance will pay for the services provided. We will attempt at the beginning of your healthcare to receive verification of your policy and what services it covers.

5. Our office will not enter a dispute with your insurance company over your claim. This is your responsibility and obligation.

Important

Most insurance plans **do not cover 100%** of the cost of your treatment. We will estimate as closely as possible your appropriate co-pay and any/all deductibles, based on the information provided by your insurance company. **We require all co-pay amounts to be paid at or before the time of service. We accept cash, check, Visa, MasterCard, & Discover.** Our office will file your insurance claims. However, we will wait a maximum of 60 days for the insurance check. (Insurance is typically paid within 45 days.) We will assist you in dealing with your insurance claims. However, if payment is not received by the 61st day, you are responsible for the remaining balance. **If your account becomes delinquent, it will be subject to finance charges. The unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month.** An account that is not paid within 90 days of invoice is generally turned over to collections or small claims court, but we may do so earlier or later in our discretion.

Initial _____ and Continue on to back of page

Authorization and Assignment

In consideration of undertaking your care, you agree to the following:

1. You authorize Discover to release any information it deems appropriate concerning your physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. You authorize the direct payment to Discover any sum you now or hereafter owe to Discover, by your attorney, out of the proceeds of any settlement of your case, and/or any insurance company obligated to make payment to you or Discover based in whole or in part upon the charges made for Discover' services.

3. If any insurance company that is obligated by contract to make payment to Discover or to you for the charges made for Discover's services refuses to make such payment upon demand, you hereby assign and transfer to Discover the cause of action that exists in your favor against any such company (the correct name(s) of which you have provided to Discover) and authorize Discover to prosecute said action in your name as Discover sees fit. You also authorize Discover to compromise, settle or otherwise resolve said claim as Discover sees fit. Until a reasonable effort has been made to collect the sums due from the insurance company or companies, Discover will refrain from collecting the amounts owed directly from you. You understand that whatever amounts Discover does not collect from insurance proceeds, whether it be all or part of what is due, you owe those amounts and agree to pay them to Discover on demand.

4. You further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed to Discover are paid in full.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns. A photocopy of the signed document will be as valid and binding as the signed original.

PLEASE READ AND SIGN THE STATEMENT BELOW

I have read, understand and accept the terms of this office policy, financial policy, & Authorization/Assignment concerning my treatment at Discover Chiropractic Center, PC. I authorize Discover Chiropractic Center, P.C. to bill my insurance company for all services rendered. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. And I understand I am responsible for any account balance.

X_____ _____

Signature of Responsible Party (Must be 18 years old) Date

X_____

Printed name of Responsible Party

X_____ _____

Staff Signature Date

(If the responsible party is not the same person as the patient, they must sign. If the patient is a minor, the parent or legal guardian must sign.)