Aery Chiropractic & Acupuncture – Confidential Health Record

Today's Date ____________________ Do you smoke? ___Y ___N

Full Legal Name ______________________________ Preferred Name ______________________

Local Mailing Address ____

Permanent Mailing Address ____

Date of Birth _________________________ EMAIL Address _____________________________

Best Phone Number ____________________________ Type of Phone ___ Cell ___ Home ___ Work

Other Pertinent Phone Numbers & Type ____

Marital Status ______________ Social Security # _________________ Occupation ______________

Employer or School __________________________________ Bus. Phone _____________________

Name of Spouse/Partner ______________________________ Phone ________________________

Nearest Living Relative ________________________________ Phone ________________________

How did you hear about our office? ___ Social Media ___ Friend/Family ___ Driving By ___ Website ___ Other

Is your visit precipitated by an accidental injury? If yes, choose from the following & describe further:

___ Auto ___ Work ___ Home ___ Leisure/Sports ___ Other

Describe: ____

When did your symptoms appear? If an accident, when did the accident occur? _______________________

If you were involved in a motor vehicle or workplace accident, provide the insurance adjustor's information and you will need to complete our Assignment of Benefits on your initial visit. _______________________________

____

Have you ever had the same or similar symptoms before? ___Y ___ N

Are these symptoms interfering with your ___Work ___Sleep ___Daily Routine ___Other?

Have you ever had chiropractic care? ___ Yes ___ No If yes, who was your doctor? ____________________

When did you seek chiropractic care & for what symptoms? _____________________________________

What are your current reasons for coming to this office, including a brief description?

___ Eliminating symptoms or disease ____

___ Preventing symptoms or disease ____

___ Maximizing health potential & nutrition ____

In the past, have you had any accidents in which you received injuries? If yes, please include dates for each:

____

Are you taking any medications or supplements? Please list here or provide your list at check-in.

____

Confidential Health Record of ________________________________ Date_________________________

List your leisure and/or recreational activities & qualify them as strenuous, moderate or sedentary.

____

Do you have any family history of ___ Heart disease ___ Diabetes ___ Cancer ___ Thyroid Issues ___ Other?

Please describe further: ____

Do you personally have history of ___ Heart disease ___ Diabetes ___ Cancer ___ Thyroid Issues ___ Other?

Please describe further: ____

Do you have a pacemaker? ___ Y ___ N Do you have any metal implants or any prostheses? ___ Y ___ N

Date of your last physical exam? _____________ Exam performed by ____________________________

For Women Only: Are you pregnant? ___ Y ___ N Date of last menstrual cycle ___________________

On a scale of 0 (no pain) to 10 (extreme pain), please list each area of your body where you have symptoms with the appropriate pain scale severity next to it.

1. ____
2. ____
3. ____

Chiropractic is beneficial for many conditions. If you have any questions about any physical complaint, please discuss these with the doctor.

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures and treatments, including various modes of physical therapy and diagnostic xrays, on me (or on the patient named below for whom I am legally responsible) by the Doctor of Chiropractic associated with this office and/or any other licensed Doctors of Chiropractic who now or in the future will work at this office or any other associated office or clinic.
I have had or will have an opportunity to discuss with the Doctor of Chiropractic and/or any other office personnel the nature and purpose of chiropractic adjustments and other procedures and treatments. I understand that no result is guaranteed.
I understand and am aware that, as in the practice of medicine in general, receiving treatment in the practice of chiropractic includes some risks, including but not limited to fracture, disc injury, stroke, dislocation and sprains. I wish to rely on the Doctor of Chiropractic to exercise her or his judgment during the course of my treatment to be in my best interest based on facts known at that time to the Doctor.
I have read (or have had read to me) the above consent. I have also had an opportunity to ask questions about the content of this consent. By signing below, I am agreeing to the whole of this consent. I intend for this consent to cover the entire course of my treatment for my present condition and for any future condition for which I seek treatment in this office or associated offices.

Patient Signature______________________________________ **Date**_________________________

Guardian or Spouse's Signature Authorizing Care______________________________ **Date**________________

Witnessed By: ______________________________________ Date_________________________

Confidential Health Record of ______________________________ Date______________________

Insurance:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. I also understand that Aery Chiropractic & Acupuncture will assist me with necessary reports and forms in order to collect from the insurance carrier and that any amount authorized to be paid directly to Aery Chiropractic & Acupuncture will be credited to my account upon receipt. I also clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment upon receipt of treatment. I also understand that if I suspend or terminate my care and treatment, any unpaid fees for services rendered to me or goods sold to me will be immediately due and payable.

Patient Signature______________________________________ **Date**______________________

Guardian or Spouse's Signature Authorizing Care________________________________ **Date**____________

HIPAA Consent Form

The office of AERY CHIROPRACTIC & ACUPUNCTURE (referred to hereafter as the or this "office") is committed to protecting your personal information. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and complies with this office's medical records retention requirements. This notice applies to the medical records maintained by this office and it specifically details the ways in which your medical information may be used and disclosed to third parties. This notice also details your individual rights regarding your medical records.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, I order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Printed Name: __________________________ Signature: ____________________________

Date: ____________________________ Witnessed By: ___________________

Confidential Health Record of ________________________________ Date ____________________

Please mark your areas of pain on the figures below. Include the severity of your pain on the scale from 0-10, with 0 being no pain & 10 being extreme pain:

0–10 Numeric Pain Rating Scale