Patient Name: _____Date: _____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

Referred by/How did you hear about us: _____

Have you ever received Chiropractic Care? Yes No

1. **Past Health History:**

   A. **Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

   B. **Previous Injury or Trauma:** _____

      Have you ever broken any bones? Which? _____

   C. **Allergies:** _____

2. **Family Health History:**

   Do you have a family history of? (Please indicate all that apply)

   □ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
   □ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
   □ Diabetes □ Other _____ □ None of the above

Patient Name: _____Date: _____

3. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities/Hobbies:_____

D. Lifestyle:

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

4. Medications:

Medication	Reason for taking

Patient Name: _____Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **oncological (cancer-related)** issues?
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal bleeding/bruising
□ Current/past oncology disease _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Helping Hands Chiropractic and Wellness Center** for services performed.

Patient or Guardian Signature _____
Date_____

Patient Name: _____Date: _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
    - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

Patient Name: _____Date: _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
    - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

Patient Name: _____Date: _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

Patient Name: _____ **Date:** _____

Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments, massages and other chiropractic procedures, including various modes of physical therapy, on me (or the patient named below, for whom I am legally responsible) by the doctor of Helping Hands Chiropractic and Wellness Center (HHCWC) and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named above, including those working at the clinic or officer listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signed:_____ Date:_____

Helping Hands Chiropractic and Wellness Center, LLC FINANCIAL POLICY

1. At the beginning of your treatment in our office we will attempt to verify your insurance benefits. However, phone, fax, or online verification of coverage is never a guarantee of payment.
2. Payment is due at the time of service. If you are unable to make payment in full, please make arrangements with you provider.
3. Balances over 90 days are subject to additional collection fees and interest charges of **35% on the total balance**.
4. If you choose to have your payment portion billed to you, there may be a $5.00 statement fee per billing cycle for outstanding balances.
5. Returned check or nonsufficient funds will be charged $30.00
6. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.
7. You will be responsible for your full deductible and co-payment or coinsurance. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are of aware of the denial.
8. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance.
9. All patients are placed on a cash basis until all necessary paperwork has been received, signed and the insurance company makes payment!
10. It is the policy of Helping Hands Chiropractic and Wellness Center, LLC to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. However, if we determine that a patient is unable to pay any out-of-pocket amounts; our practice may waive or lower such amounts.
11. Any and all discounted offers expire immediately upon a defaulted payment, making the full balance immediately due.

Patient Signature/or guardian if minor:_____ Date:_____

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Helping Hands Chiropractic and Wellness Center, LLC. I give Helping Hands Chiropractic and Wellness Center permission to contact any person listed as parent/spouse/guarantor/contact unless they are excluded on the exclusion form.

Patient Name: _____Date: _____

Cancellation and No-Show Policy Agreement

Appointment Changes and Cancellations: Cancellations or changes to an appointment must be requested at least 24 hours prior to the scheduled appointment time.
Late cancellations (less than 24 hours notice) and No-Show appointments will incur a full visit charge (may vary depending on if it is an initial visit or follow up visit), which will be billed directly to the patient.
Impact of Repeated Late Cancellations: Repeated late cancellations disrupt the optimal delivery of care to both you and other patients. Missed appointments also negatively impact the consistency of your care program.

No Show Policy:

- After one missed appointment ("No Show") it is required to have a card on file to be billed for further missed appointments.
- After two missed appointments ("No Show"), future appointments will only be scheduled as same-day appointments.

Late Cancellation Policy:

- After one late cancellation (less than 24 hours notice), it is required to have a card on file to be billed for further late cancellations.
- After two late cancellations (less than 24 hours notice), future appointments will be cancelled and will only be rescheduled as same-day appointments.

By signing below, you acknowledge that you have read, understand and agree to the terms of the No Show and Late Cancellation Policy as outlined above.

Client Signature:_____Date:_____

Text Message Alert Consent

I hereby give my consent for Helping Hands Chiropractic and Wellness Center to send text messages to my mobile telephone (as per the number provided below). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment, or an alert of any specials. Text message/data charges from my cell phone provider may apply. I understand that the only way to cancel an appointment at HHCWC is by phoning the office or stopping by. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information PHI in this fashion.

_____ #_____

Signature Cell #

