Canyon Chiropractic Center

Patient Information Today's Date: _____

Patient (Legal Name): _____

Preferred Name : _____ Date of Birth: _____ Age:_____

How did you hear about us?: [ ] Facebook [ ] Instagram [ ] Google [ ] Our Website [ ] Other: _____

Referred by: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Email Address: _____

Would you like to subscribe to our Newsletter for Updates, Promotional Discounts, and Events? [ ] Yes [ ] No

Home Phone: _____ Cell: _____ Cell Provider: _____

Sex: [ ] Male [ ] Female Marital Status: [ ] Married [ ] Single [ ] Divorced [ ]Widowed

Name of Spouse: _____

Name of Emergency Contact: _____

Relationship:_____

Emergency Contact Address: _____

Phone #: _____

Employment Information: Patient (18 or older) or Responsible Party:

Work Status: [ ] Employed [ ] Retired [ ] Student [ ] Unemployed

Business Employer: _____ Type of Work: _____

Business Phone: _____

Employer Address: _____

Current Health History

Purpose of this Appointment: _____

Other Doctors seen for this condition: [ ] Yes [ ] No Who?_____

_____

Type of treatment: _____

Results: _____

When did this condition begin: _____

Has this condition occurred before? [ ] Yes [ ] No

What makes your condition better or worse? (*Mark with a "**B**" or "**W**"*)

[ ] Lying Down [ ] Walking [ ] Standing [ ] Daily activities [ ] Exercise [ ] Inactivity

Does it interfere with: [ ] Work [ ] Sleep [ ] Daily routine [ ] Other:_____

Is Condition: [ ] Job Related [ ] Auto Accident [ ] Home Injury [ ] Fall [ ] Other_____

Date of Accident: _____ Time of Accident: _____

Are you currently taking any medications? [ ] Yes [ ] No

Medication Name & Dosage/Frequency:

_____

_____

Are you currently taking any supplements? [ ] Yes [ ] No

Supplements Name & Frequency:

_____

_____

Do you currently wear: [ ] Orthotics [ ] Heel Lifts [ ] Sole Lifts

Do you have any other complaints *other than* that which you are now consulting us?

_____

Name of your Primary Care Provider? _____

Office Phone: _____

Do you have any medication allergies? [ ] Yes [ ] No

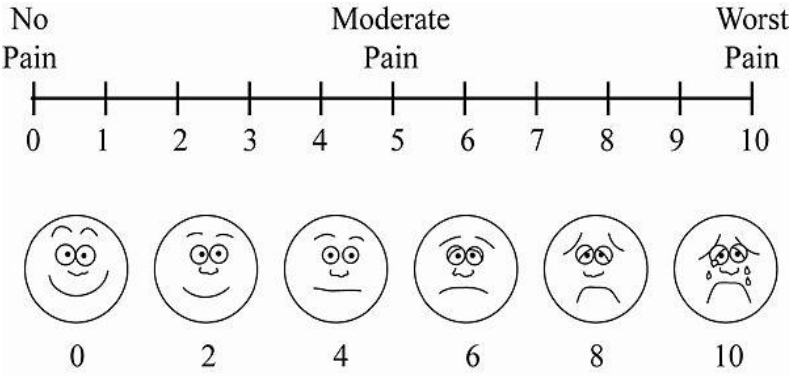
If yes, please explain: Medication Name/ Reactions/ Onset Date/ Comments:

_____

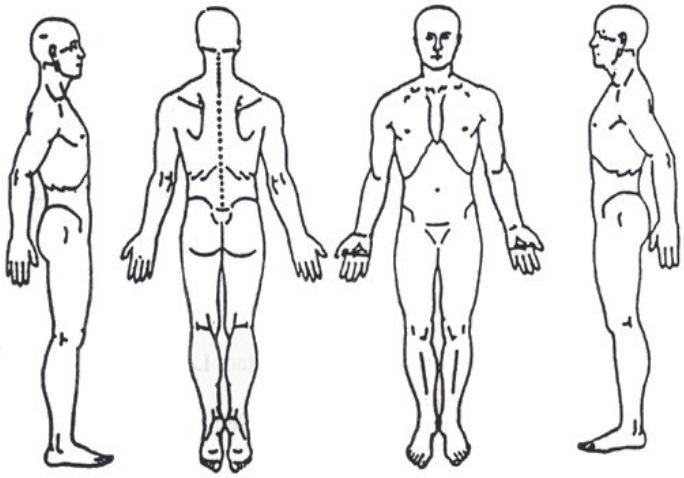
_____

Please check the expectation of your care with us:

[ ] Quick Fix ("Band-Aid") [ ] Full Recovery of Injury or Problem [ ] Lifestyle Change with Maintenance



Mark an **X** where you have pain/other symptoms below:



Frequency:

[ ] **Constant**
(*all day*) (76-100%)
[ ] **Frequent**
(*most of the day)* (51-75%)
[ ] **Occasional**
(*some of the day)* (26-50%)
[ ] **Intermittent**
(*off & on during the day)* (25% or less)

Description:

[ ] Sharp Pain	[ ] Dull Pain
[ ] Ache	[ ] Weak
[ ] Throbbing	[ ] Numb
[ ] Shooting	[ ] Gripping
[ ] Burning	[ ] Tingling

Lifestyle

Do you exercise? [ ]Yes [ ] No How many times per week?_____
What activities? [ ] Running [ ] Jogging [ ] Weight Training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming
[ ] Other _____

Smoking Status: [ ] Every Day Smoker [ ] Occasional Smoker [ ] Former Smoker [ ] Never Smoked
Do you drink alcohol? [ ] Yes [ ] No How much / week? _____
Do you drink coffee? [ ] Yes [ ] No How many cups / day? _____
Do you drink water? [ ] Yes [ ] No How many cups / day?_____
Blood Pressure: [ ] Normal [ ] Low [ ] High
General Stress Level: [ ] None [ ] Minimal [ ] Moderate [ ] Greatly Stressed

Please mark Health Topics you would like to learn more about:

[ ] Wellness/Holistic Topics [ ] Stress Management [ ] Exercise/Fitness [ ] Headaches/Neck Pain [ ] Sports
[ ] Back Pain [ ] Posture/Ergonomics [ ] Diet and Nutrition [ ] Children's Health [ ] Women's/Men's Health

Past Health History:

Surgery / Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gallbladder [ ] Ear Tubes/Adenoids

[ ] Broken Bones [ ] Back / Neck Surgery

[ ] Other : _____

Accidents or Falls: _____

_____

Hospitalizations (other than above): _____

_____

Date of last physical exam: _____

Previous Chiropractic Care: [ ] None [ ] Doctor's Name & Approximate Date of Last Visit:

_____

Were X-rays taken? [ ] Yes [ ] No Date X-rays were taken:_____

Health Conditions:

Have you experienced any of the following in the past or currently? Please indicate YES or NO for each.

Musculoskeletal

Yes No

- ☐ ☐ Disc Problem
- ☐ ☐ Muscle Cramping
- ☐ ☐ Joint Pain
- ☐ ☐ Stiffness
- ☐ ☐ Bursitis or Tendinitis
- ☐ ☐ TMJ Pain / Chewing Difficulty
- ☐ ☐ Scoliosis

Neurologic

- ☐ ☐ Walking Problems
- ☐ ☐ Restless Leg Syndrome
- ☐ ☐ Dizziness / Vertigo
- ☐ ☐ Forgetfulness
- ☐ ☐ Confusion
- ☐ ☐ Depression
- ☐ ☐ Fainting
- ☐ ☐ Epilepsy / Convulsions
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Coldness in Hands / Feet
- ☐ ☐ Stress
- ☐ ☐ Anxiety

EENT

- ☐ ☐ Vision Problems
- ☐ ☐ Dental Problems
- ☐ ☐ Sore Throat
- ☐ ☐ Earaches
- ☐ ☐ Sinusitis
- ☐ ☐ Hearing Problems
- ☐ ☐ Ringing in Ear(s) / Tinnitus
- ☐ ☐ Stuffy nose
- ☐ ☐ Allergies
- ☐ ☐ Fever

Gastrointestinal

Yes No

- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Hemorrhoids
- ☐ ☐ Poor or Excessive Appetite
- ☐ ☐ Nausea
- ☐ ☐ Unexplained Weight Loss
- ☐ ☐ Weight Problems
- ☐ ☐ Liver Problems
- ☐ ☐ Gallbladder Problems
- ☐ ☐ Kidney Problems
- ☐ ☐ Abdominal Cramping
- ☐ ☐ Black or Bloody Stool
- ☐ ☐ Indigestion/Heartburn
- ☐ ☐ GERD/Reflux
- ☐ ☐ Hernia
- ☐ ☐ Ulcers/Gastritis
- ☐ ☐ Gas After Eating
- ☐ ☐ Tired / Irritable after Eating

Genitourinary

Males Only

- ☐ ☐ Male Specific Issues

Females Only

- ☐ ☐ Polycystic Ovarian Syndrome
- ☐ ☐ Endometriosis
- ☐ ☐ Heavy Bleeding with Cycles
- ☐ ☐ Breast Tenderness / Fibrocysts
- ☐ ☐ Vaginal Pain or Infection
- ☐ ☐ Hot Flashes
- ☐ ☐ Menstrual/Cramp Irregularities
- ☐ ☐ Are you Pregnant?
- ☐ ☐ Sexual Dysfunction
- ☐ ☐ Recurrent Bladder Infections
- ☐ ☐ Frequent / Difficulty Urinating
- ☐ ☐ STD

Date of Last Period: _____

Cardiovascular/Respiratory

Yes No

- ☐ ☐ High / Low BP
- ☐ ☐ Fast / Slow Heart Rate
- ☐ ☐ Hypoglycemia
- ☐ ☐ Anemia
- ☐ ☐ Stroke
- ☐ ☐ Vascular Disease
- ☐ ☐ Heart Murmurs
- ☐ ☐ Pacemaker
- ☐ ☐ Heart Attacks / Angina
- ☐ ☐ Heart Palpitations
- ☐ ☐ Ankle Swelling
- ☐ ☐ Varicose Veins
- ☐ ☐ Recurrent Lung Infections
- ☐ ☐ Lung Congestion
- ☐ ☐ Persistent Cough
- ☐ ☐ Pneumonia
- ☐ ☐ Pain On Deep Breathing
- ☐ ☐ Dizzy when Standing Suddenly
- ☐ ☐ Chest Pain
- ☐ ☐ Shortness of Breath
- ☐ ☐ Asthma / Wheezing

Metabolic/Other

- ☐ ☐ Headaches / Migraines
- ☐ ☐ Insomnia / Loss of Sleep
- ☐ ☐ Night Sweats
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Thyroid Disease
- ☐ ☐ Low Energy / Fatigue
- ☐ ☐ Reduced Bone Density
- ☐ ☐ White Spots on Fingernails
- ☐ ☐ Bleeding Disorder
- ☐ ☐ Perspire Easily-even if not hot
- ☐ ☐ Bruise Easily

Consent to Treatment:

Please initial each statement:

_____ I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment at Canyon Chiropractic Center.

Release of Records:

_____ I hereby authorize the release of medical records, or information necessary to process my claim, to my insurance company, adjuster, or attorney as applicable.

Financial Responsibility and Assignment of Benefits:

_____ Payment is due at the time of service. Patients are ultimately responsible for all charges incurred by treatment in this office.

_____ Canyon Chiropractic Center is not in network with insurance companies. All patients are encouraged to call the member services number on their insurance card to inquire about their plan coverage for chiropractic treatment and any associated deductibles, limitations, exclusions, precertification needs, pre-existing condition clauses, etc. Canyon Chiropractic Center can provide the appropriate forms containing diagnostic codes and prices for patients to submit to their insurance themselves. Patients are responsible for knowing their insurance benefits and limitations prior to scheduling appointments. **Insurance patients are ultimately responsible for all charges incurred by treatment in this office**.

_____ In order to provide you and our other patients with optimal spinal care, we request that you follow our guidelines regarding broken/cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to complete their treatment. A $30 cancellation fee will be charged to your account if you either miss or cancel your appointment without the appropriate 24-hour notice. **I understand I will be charged for any appointments I miss if I do not give 24 hours cancellation notice without good cause.**

_____ I hereby assign to this practice, Canyon Chiropractic Center, all monies to which I am entitled through insurance for treatment expenses relative to the service rendered by this practice, but not to exceed my indebtedness to said practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as it is determined to be appropriate, when my bills are paid in full.

_____ I understand I am financially responsible to Canyon Chiropractic Center for all charges not covered by the above assignment. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be 18% per annum of the principal balance for any debt incurred hereunder and to pay all reasonable LEGAL COSTS as a result of my default.

I certify that I have read this form and understand its contents.

_____ _____

Patient -18 or older- or other Legally Authorized Person **Date**

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to all this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient -18 or older- or other Legally Authorized Person **Date**

CANCELLATION POLICY

In order to provide you and our other patients with optimal spinal care, we request at least **24 hours** notice in order to reschedule your appointment. Please remember that we have reserved appointment times especially for you. By allowing us at least 24 hours notice, it will enable us to offer your cancelled time to other patients that desire to complete their treatment. A **$30 cancellation fee** will be charged to your account if you either miss or cancel your appointment without the appropriate 24-hour notice. Thank you for your respect.

Signature of patient: _____

Additional Notes: