Chiropractic Health Questionnaire Pt # _____

Camp Hill Family Chiropractic, PC

Name_____ **Best Phone # to Contact** _____ **H C W**

Address_____ **City, State, Zip** _____

Birth Date _____/_____/_____ **Age**_____ **E-mail Address**_____

Occupation_____ **Employer**_____ **Work Phone** _____

Under 18 yoa: Mother's Name _____ **Father's Name** _____ **Phone** _____ **H C W**

Guardian's Name _____ **Relationship** _____ **Phone** _____ **H C W**

Marital Status: S M W D Sep **Mates Name** _____ **Children (Ages)** _____

1. **Most patients are referred to our office** by a caring family member or friend. **How did you find out about us?**

   Name _____ Walk-in / Call / Talk / Phone Book / Media / Web / Screening / Ins. Co.

2. Research shows that **your spine should be checked regularly**. **Have you ever been to a Chiropractor before? Yes No**
   If yes, When? _____Who? _____ # of Visits _____

3. When was your last complete **spinal examination**? Never Date _____ **Last X-ray of your spine**? Never Date _____

4. **Poor posture leads to poor health** and often indicates a **spinal problem.**
   How would you **rate your posture**? **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**

5. **Stress can cause or accelerate spinal damage.** Rate your stress level. **Low** 1 2 3 4 5 6 7 8 9 10 **High**

6. What is your **Chief Complaint** today? _____

   When did it **begin**? _____ What **activity** were you doing? _____

   Is your condition? *Mild Moderate Severe* **Rate your symptom currently:** _____ ***/10*** *(Severe)*

   Daily Activities *Restricted*: (Circle) *Work Sleep Daily Routine Recreation*

   Movements that are *Painful to Perform*: (Circle) *Sit Stand Walk Bending Lying Running Twisting*

   What Treatment have you *already received* for this condition? ___ Surgery ___ Physical Therapy ___ Chiropractic

   Other _____ Medications: List _____

7. Auto **and work–related injuries can cause serious spinal problems**.
   Is this visit related to a(n): Auto Accident or Work Injury? **No Yes Date of Incident** _____

8. **Spinal problems can cause a variety of health issues.** Please check the health complaint(s) you are currently experiencing:

○ Neck Pain	○ Arm or Hand Pain	○ Carpal Tunnel	○ Chronic Fatigue	○ Jaw Pain
○ Mid Back Pain	○ Leg, Knee, Foot Pain	○ Ear Infections	○ Arthritis	○ Dizziness/Balance
○ Low Back Pain	○ Sciatica	○ Frequent Colds	○ Fibromyalgia	○ Asthma
○ Shoulder Pain	○ Plantar Fasciitis	○ Digestion	○ Headaches	○ Allergies/Sinus

   Others _____

9. Females, spinal health is especially important during pregnancy. **Is there any chance that you are pregnant**? **Yes No**

10. If the doctor feels that Chiropractic will help you, **are you willing to follow his recommendations? Yes No**

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, RECORDS PERMISSION

My signature implies consent for treatment. I request payment of government benefits and other of medical benefits to this office, if accepting assignment. I authorize the release any medical information or other information necessary to process a claim. I authorize this office to obtain medical records from other healthcare facilities. (If under 18, a parent or guardian's signature is required).

Signature _____ **Date** _____ 2017

OFFICE USE

OCC	**T1**	**L**
C1 / 30	**T**	**L**
C	**T**	**SAC**
C	**T / L**	**ILIUM**

Camp Hill Family CHIROPRACTIC
wellness made simple

Welcome to Our Office!

It is our pleasure to serve you today.
To help us better understand your needs, please answer the following questions:

Name: _____ **Date:** _____

My Purpose For Today's Appointment Is:

Please check all that apply to you.

☺ I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.

☺ I'm here for an evaluation because I'm having health challenges and I'm looking for a natural health solution.

☺ I'm here for an evaluation. I am curious to know if my spine is healthy and to see if I have any problems that I don't know about.

☺ I am here for an evaluation because I'm curious to learn more about Chiropractic Care.

☺ I am only here for an evaluation.

☺ Other: _____

If The Doctor Feels He Can Help You:

Please check all that apply to you.

☺ I am willing to follow the doctor's recommendations because I strongly value my health.

☺ I am willing to receive care if cost-effective payment plans are available.

☺ I am willing to receive care, but only if my insurance will pay for <u>all</u> of it.

☺ I am not interested in receiving any care.

What Are Your REAL Health Goals?

We want to help you improve your health & your life. What could you do *better* if your symptoms were gone?

1. _____
2. _____
3. _____

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p: 717-761-8840 ~ f: 717-761-8842

Camp Hill Family Chiropractic, PC

157 S. 32nd St., Camp Hill, PA 17011

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Patient Approval for Chiropractic Care and Services

Informed Consent to Chiropractic Care

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Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below for whom I am legally responsible) by the Doctor of Chiropractic named in this document.

Though Chiropractic adjustments and treatments are usually beneficial and seldom any problem, I understand and am informed that there may be some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, strains, muscle and/or joint tenderness. 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 understand that Chiropractic is not an exact science and that by being treated in this clinic that it does not guarantee results.

I understand that I may be receiving any of the following treatments:

Consultation and Bio-Structural Examination	Chiropractic Adjustments (hands-on and/or with low force instruments)
Flexion and Distraction Traction of the Spine	Cervical Traction
Ice and/or Heat	Rehabilitation Strengthening and Stretching Exercises

X-Ray Consent

(Please Note: Your X-rays are a document of your file and the property of this office.)

The Doctor or Assistant has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral Subluxations and to determine the appropriateness of Chiropractic spinal adjustments. If the doctor discovers a non-Chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the Chiropractic care provided by this office. *** If under 18 yoa, a Guardian must consent for approval for x-rays.**

FEMALES:

If there is any possibility that you may be pregnant, notify the doctor, as x-rays might not be taken at this time. **DLMC:** _____

Pregnancy Release:

This is to certify that to the best of my knowledge, I am NOT pregnant. I understand that there are risks of taking x-rays to an unborn child. I fully understand the above release and consent Camp Hill Family Chiropractic to perform an X-ray examination on me today and in the future.

Patient (Guardian) X-ray Consent Signature: _____ **Date:** _____

Terms of Acceptance

When a patient seeks Chiropractic Health Care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our main method of correction is by specific adjustments of the spine and/or extremities.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation. However, if during the course of a Chiropractic Spinal Examination, we encounter Non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.

OUR ONLY METHOD is specific adjusting to correct vertebral Subluxations.

Notice of Privacy Practices for Protected Health Information (HIPAA)

I have been offered a copy of our HIPPA document for review and was given an opportunity to ask questions regarding how my health information is protected at this practice.

Consent for treatment, Assignment of Benefits, Release of Information, Records Submission

My signature implies consent for treatment. I request payment of government benefits and other medical benefits to this office, if accepting assignment. I authorize the release of any medical information or other information necessary to process a claim. I authorize this office to obtain medical records from other healthcare facilities.

Patient Signatures to Approve for Chiropractic Care and Services at Camp Hill Family Chiropractic, PC

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. By signing below, I acknowledge that I have received a copy of the documents above. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment. This document will expire in seven years after the signature date

Print Patient's Name: _____ Date: _____

Patient Signature: _____

Consent to evaluate and care for a minor child (under 18 years of age):

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature of Parent/Guardian: _____ Date: _____

Staff Signature: _____