Acct# _______________

PATIENT DEMOGRAPHICS

Name__________________________________ Phone_______________ SSN _____________

Address_____________________________________ City________________Zip___________

Age________Birth Date____________________ Gender _________ Marital Status: S M D W

Email Address ____

Occupation_________________ Employer____________________ Phone__________________

How Many Children _________ Name of Spouse_____________________________________

Emergency Contact___________________________Phone______________________________

Referred by_____________________________________(List person's name, location, or event)

Purpose of this Appointment ____

Other Doctors seen for this condition ____

Remarks and additional information (if female, is there any possibility you may be pregnant?)____

PAYMENT IS EXPECTED AT TIME OF VISIT.

Insurance card given to front desk? Yes No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. 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. In addition, I authorize this facility to release any information acquired in the course of my treatment to my insurance carrier(s) as necessary to process my insurance claim.

PATIENT'S SIGNATURE _________________________________ DATE__________

GUARDIAN/PARENT SIGNATURE_________________________DATE__________

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Case History

Name____ Date________________

Have you ever received Chiropractic Care? Yes/No When?___________________________

Primary reasons for seeking chiropractic care:

Primary reason:____

Secondary reason:____

Other factors contributing to the primary and secondary reasons:_________________________

Chief Complaint: ____

Complaint started when and how? ____

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other _____________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?____________

Do you have any numbness or tingling in your body? Where? ______________________________

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is complaint present, how long does it last? _________________________________

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

Dr Notes: ____

Secondary Complaint:____

Complaint started when and how? ____

Quality of complaint/pain (circle): Dull Ache Sharp Shooting Burning Throb Other ____________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?____________

Do you have any numbness or tingling in your body? Where? ______________________________

Grade Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10(Worst possible pain imaginable)

How frequent is complaint present, how long does it last? _________________________________

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

Dr Notes: ____

Previous treatments, medications, surgery, or care you've sought for your complaints:

____

____

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Name________________________________ Date_________________

Circle what you are currently experiencing:

Dizziness	Depression	Kidney Stones	Liver Disease	Nervousness
Headaches	Thyroid Problems	Mid Back Pain	Shoulder Pain	Epilepsy
Vertigo	Asthma	Irritable Bowl	Chronic Fatigue	Knee Pain
Ear Infection	Ulcer	Sciatica	Lupus	Infertility
Nausea	Numbness in Arms	Numbness in Legs	Fibromyalgia	Gastric Reflux
TMJ	Numbness in Hands	Numbness in Feet	Chest Pain	Neck Pain
Low Back Pain	Menstrual Disorder	Migraines	Heart Disorder	Hip Pain
ADD/ADHD	Anxiety	Stomach Disorder	Bladder Problem	Chronic Sinusitis

Other:____

Past Health Information

Circle any condition you have now/ have had:

Stroke	Cancer	Heart Disease	Spinal Surgery
Spinal Fracture	Seizures	Scoliosis	Diabetes

List all Surgical Operations and Years: ____

____

List ALL over the Counter & Prescription medications you are on:______________________________

____

____

Other information : ____

____

____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the Patient to be working towards the same objective. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social wellbeing, not merely the absence of symptoms or disease.

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 musculoskeletal/ nervous system. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you.

We do not offer advice regarding treatment prescribed by others. Ignite Chiropractic & Wellness' objective is to eliminate interference with the nervous system. Our method is specific joint adjusting to correct vertebral subluxations. Therapy is available to decrease the musculoskeletal agitation to the spine.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

I, ________________________________ have read and fully understand the above statements.

Signature ____ Date_____________________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment , or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature ____ Date____________________________

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INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

____
Print Name Here

___________________________________ ___________________
Signature (Minor must have Parent/Guardian sign) Date

Release of Information

If you would like Ignite Chiropractic & Wellness to release account information to someone other than yourself, please provide the name of that person below and sign.

Person's Name ____

Patient Signature ____

Acct# _______________

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAY REPORTS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF IGNITE CHIROPRACTIC & WELLNESS DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

PRINTED NAME ______________________________________ DATE _____________________________

SIGNATURE ____ YOUR AGE ____________

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT IGNITE CHIROPRACTIC & WELLNESS.

SIGNATURE ______________________________________ DATE _____________________________

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE

Name:					
Acct #:					
Date:					
Cerv. A-P	Cerv Lat	Thor A-P	Thor Lat	Lumbar A-P	Lumbar Lat