

# Revive Family Chiropractic Health Profile

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Male/Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation \_\_\_\_\_ Name of Employer \_\_\_\_\_  
Single / Married / Divorced / Widowed Spouse's Name \_\_\_\_\_  
Number of Children \_\_\_\_\_ Names, Ages & Gender \_\_\_\_\_

Do you independently make your own financial decisions for your Health Care? Circle: Yes No  
If not, please provide your parent/guardian Name, Phone Number, and Best Time to be Reached that makes the Financial Decisions regarding your Health Care: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List According to Severity	Rate of Severity 1-Mild 10-UNBEARABLE	When did this episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are Symptoms Intermittent or Constant?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF YOU ARE EXPERIENCING PAIN, IS IT: SHARP \_\_\_\_\_ DULL \_\_\_\_\_ BURNING \_\_\_\_\_

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? CIRCLE: YES NO

IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE ITS PATTERN \_\_\_\_\_  
\_\_\_\_\_

SINCE YOUR PROBLEM STARTED, IS IT: THE SAME \_\_\_\_\_ GETTING BETTER \_\_\_\_\_ GETTING WORSE \_\_\_\_\_

WHAT MAKES IT WORSE? \_\_\_\_\_

WHAT MAKES IT BETTER? \_\_\_\_\_

WHAT HAVE YOU DONE THAT MAKES IT BETTER? \_\_\_\_\_

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? CHIROPRACTOR \_\_\_\_\_ MD \_\_\_\_\_ OTHER \_\_\_\_\_

NAME & PHONE NUMBER OF PREVIOUS DOCTOR \_\_\_\_\_

LIST SURGICAL OPERATIONS AND YEARS \_\_\_\_\_  
\_\_\_\_\_

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LIST ALL MEDICATIONS YOU ARE ON \_\_\_\_\_

WHEN WAS YOUR LAST AUTO ACCIDENT \_\_\_\_\_

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE?      CIRCLE:                      YES                      NO  
IF YES, DR. & LAST VISIT DATE \_\_\_\_\_

HAVE YOU EVER BEEN UNCONSCIOUS?                      CIRCLE:                      YES                      NO

HAVE YOU EVER FRACTURED A BONE?                      CIRCLE:                      YES                      NO  
IF YES, PLEASE DESCRIBE \_\_\_\_\_

ANY OTHER BODILY TRAUMA? \_\_\_\_\_

## PLEASE CIRCLE AN AND ALL CURRENT PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS

ASTHMA	ARTHRITIS	TMJ	CHRONIC FATIGUE
EPILEPSY	GASTRIC REFLUX	HEART DISORDERS	LUPUS
ULCERS	SCIATICA	IRRITABLE BOWEL	NAUSEA
DIZZINESS	NUMBNESS IN ARMS	DISC PROBLEMS	MENSTRUAL DISORDER
KIDNEY PROBLEMS	NUMBNESS IN HANDS	LIVER DISEASE	NECK PAIN
HEADACHES	NUMBESS IN LEGS	LOW BACK PAIN	MIGRAINES
VERTIGO	NUMBNESS IN FEET	MID BACK PAIN	STIFFNESS IN NECK
CHEST PAINS	EAR INFECTIONS	STOMACH DISORDER	HIP PAIN
ARM PAINS	GRATING IN NECK	LEG PAIN	ANXIETY
NERVOUSNESS	SHOULDER PAIN	FAINTING	CHRONIC SINUS
DEPRESSION	INSOMNIA	BLADDER DISORDER	
OTHER _____			

## LIST SYMPTOMS/COMPLAINTS IN ORDER OF DISCOMFORT

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

## PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW/HAVE HAD IN THE PAST:

STROKE    CANCER    HEART DISEASE    SPINAL SURGERY    SEIZURES    SPINAL BONE FRACTURE    SCOLIOSIS    DIABETES

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## FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE \_\_\_\_\_

PLEASE PRINT YOUR NAME HERE \_\_\_\_\_

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

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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, MOST OFTEN VERY MINIMAL, YET IN RARE CASES 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 INSTANCE PER TWO MILLION OF CERVICAL SPINE (NECK) ADJUSTMENTS, MAY BE A VERTEBRAL ARTERY INJURY THAT COULD LEAD TO 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 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 A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

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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.

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PRINT PRACTICE MEMBER'S NAME HERE

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PRACTICE MEMBER'S NAME

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DATE

IF PRACTICE MEMBER IS A CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

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SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

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WITNESS SIGNATURE (OFFICE STAFF)

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DATE

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## TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic.

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a *specific* directional thrust to a region or regions of the spine with specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified you will receive a prompt referral to an appropriate provider or specialist according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or any other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, as we work to maintain a supportive, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction, I thereby accept chiropractic care on this basis.

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Signature

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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:

- A. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- B. Obtain payment from third party payors.
- C. Conduct normal healthcare operations such as quality assessments and physician 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 used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if agreed, then you are bound to abide by such restrictions.

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Signature

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Date