Thank you for choosing Healthy Spines Chiropractic

Date:______________________
Legal Name:____ Nickname:_____________________
Address:______________________________________ City: ____________State:____ Zip:_______
Home Phone: ______________________ Cell Phone:_____________________________________
Email:____
Date of Birth:______________________________ Age:_________ Marital Status: [S] [M] [D] [W]
Occupation: _________________________Spouse's Name:________________________________
Children's Name & Age:____
Name & Phone No. of Emergency Contact:____
Have you ever received Acupuncture Care? [No] [Yes]-When? ____________________________
Have you ever received Chiropractic Care? [No] [Yes]-When?_____________________________
Have you ever received Massage Therapy? [No] [Yes]-When?______________________________
Have you ever been injured in an accident/trauma? [No] [Yes]-Date of accident:
____
Are you Pregnant? [No] [Yes]-How many weeks:______________________________________
Who referred you to Healthy Spines Chiropractic:_______________________________________

What brings you in today?:

____
____
____
How long have you suffered with these complaints?______________________________________
Are these complaints interfering with: [Work] [Sleep] [Routine] Other:______________________
Are you getting worse? [No] [Yes]-How?____
Other doctors seen for these complaints? [No] [Yes]-Who?_______________________________
Have you experienced this in the past? [No] [Yes]-How many times?_________________________
Do you have allergies?:____
Any other conditions?
____
____
____

Please check all that apply:

- ❑ Headache
- ❑ Neck Pain/Stiffness
- ❑ Sleeping Problems
- ❑ Back Pain/Stiffness
- ❑ Nervousness
- ❑ Tension/Irritability
- ❑ Cold Sweats
- ❑ Fainting
- ❑ Fever
- ❑ Numbness in Legs
- ❑ Numbness in Arms
- ❑ Numbness in Hands
- ❑ Numbness in Feet
- ❑ Dizziness/Balance Loss
- ❑ Ears Ring/Buzz
- ❑ Diarrhea
- ❑ Constipation
- ❑ Fatigue
- ❑ Cold Feet
- ❑ Cold Hands
- ❑ Loss of Memory
- ❑ Stomach Upset
- ❑ Depression
- ❑ Lights Bother Eyes

Patient Health Questionnaire

HEALTHY SPINES CHIROPRACTIC

HEALTHY SPINES CHIROPRACTIC USE ONLY

*Patient Name*_______________________ *Date* _______________________

1. When did your symptoms start: _______________________

Describe your symptoms and how they began:

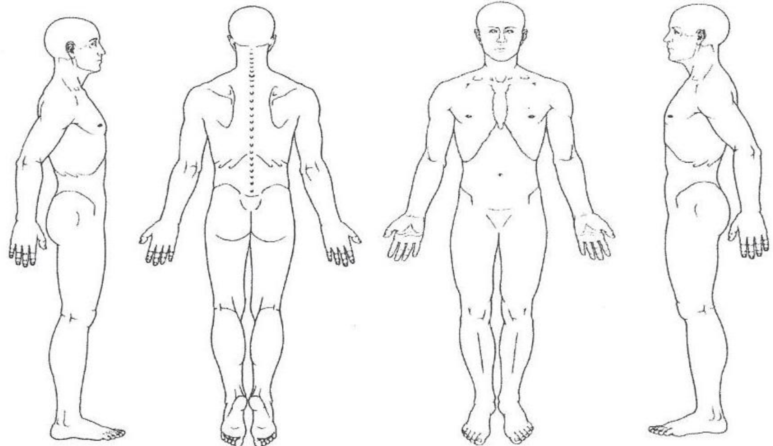
____

____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _______________________

8. What activities make your symptoms better: _______________________

9. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? _______________________

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* ________ ☐ CT Scan *date:* ________

☐ MRI *date:* ________ ☐ Other *date:* ________

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation?

____

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply)*:

- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

*Patient Signature*_______________________ *Date* _______________________

Patient Health Questionnaire - page 2

HEALTHY SPINES CHIROPRACTIC

HEALTHY SPINES CHIROPRACTIC USE ONLY

Patient Name ______________________ *Date* ____________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ] [ ] [ ] Feet Inches Weight [ ] [ ] [ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS
Females Only		
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	
Other Health Problems/Issues		
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ____________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ *Date* ____________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ *Date* ____________

Dear New Patient: Our experience has shown that it is wise to have an understanding with our patients as to our office fee policies. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan which best fits your needs. This information will enable us to better serve you and help avoid any misunderstanding in the future. If special arrangements are necessary, please discuss with the doctor during your consultation. Our main concern is your health and wellbeing, and we will do our best to help you.

CASH PLANS: You are expected to pay in full for today's services. Fees are to be paid at the time services are rendered unless special arrangements have been made in advance. We accept Cash, Check, American Express, MasterCard, Visa and Discover. For active patients who qualify, you may enroll in one of our care programs which allows care to be paid for on a monthly basis. The Doctor/Therapist will discuss your options with you after they find out if they can help you. Some restrictions apply.

PROFESSIONAL FEE SCHEDULE

Consultation .... No Charge
Examinations $15-100
Spinal Adjustments $35
Adjunctive Therapies .... $15 - $60
Massage Therapy .... $55 - $200

Other Services and their pricings can be found online at www.healthyspineschiropractic.com/pricing

INSURANCE: In order for Healthy Spines Chiropractic to stay affordable for all patients we lowered our prices to those that match most deductibles, because of that Healthy Spines Chiropractic does not accept insurance. Healthy Spines Chiropractic is also a wellness clinic and does not focus on active care rather on preventive care which most insurances and Medicare do not cover. Upon request we will print off a report for your records to your Health Savings Accounts. Family plans are available. Ask Dr. Heather for details.

WORK RELATED, AUTO & PERSONAL INJURY: Healthy Spines Chiropractic is a wellness clinic and will not be accepting Work Related, Auto & Personal injury cases at this time.

MEDICARE: Medicare recipients must present their enrollment cards at the onset of care. Spinal manipulation is the ONLY service covered by Medicare. There is no guarantee Medicare will pay for any more than 12 visits. All non-covered services (such as exams and x-rays) must be paid-in-full at the time of service.

24 HOUR CANCELATION POLICY - Should I cancel or miss an appointment with less than 24 hours' notice, I authorize Healthy Spines Chiropractic, inc. to charge my VISA/MC/Amex/Discover or checking account for the full session fee.________**Intial Here**

EMAIL POLICY - We will use your email address for appointment reminders, promotions and news from Healthy Spines Chiropractic. Your privacy is important to us. We will not sell, rent or give your name or address to anyone. To unsubscribe or to receive less or more information, you can select a link at the bottom of every email.________**Intial Here**

By signing below, I verify that I have read the Above Policies.

Patient or Guardian's Signature :________________________________ Date:____________

Terms of Acceptance

When a patient seeks care at Healthy Spines Chiropractic, inc., and when the Chiropractor and/or Therapist accepts a patient for care, it is essential that both are seeking and working for the same goal-to locate, analyze and correct spinal interference to the nervous system which may lead to a muscular skeletal conditions. 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.

We do not diagnose conditions of disease other than that which relates vertebral subluxations and muscular skeletal conditions. However, if during the course of your care, we encounter complaints that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxations and muscular skeletal conditions. Our primary role for chiropractic is to identify subluxations and our primary method of correcting them is through spinal adjustments. For Massage Therapy and Acupuncture our goal is to decrease the interference on the muscular skeletal system. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service. By signing below, I agree to all the terms outlined.

Patient or Guardian's Signature :________________________________ Date:____________

Informed Consent to Treatments

Acupuncture: I hereby request and consent to the performance of Acupuncture and other Acupuncture procedures, including various Therapy modes such as Acugraph and Earseeds by Dr. Heather and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Dr. Heather. I understand that the Acupuncture I receive is provided for the basic purpose of Muscular skeletal conditions or for relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I should immediately inform my Acupuncturist so that the treatment can be adjusted. I understand and am informed that, as in the practice of medicine, in the practice of Acupuncture there are some risks to treatment, including but not limited to bruising, bleeding, inflammation, soreness around the insertion site, infection, and in rare cases damage to an internal organ, collapsed lung. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I understand that Acupuncture should not be construed as a substitute for medical examination, diagnoses or treatment and that I should consult with a physician or another qualified medical specialist for any ailment that I am aware of. I understand Acupuncturist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical, emotional or mental illnesses. Because Acupuncture should not be performed under certain medical conditions, I affirm that I have stated all my known conditions and answered all questions honestly. I agree to keep my Acupuncturist up to date on all changes to my medical conditions and understand that there shall be no liability on the part of the Acupuncturist should I neglect to do so. I also understand that any illicit or sexual suggestive remarks will result in immediate termination of session and no future appointments will be made. I have read this consent 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.

Patient or Guardian's Signature :_________________________________ Date:____________

Chiropractic: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by Dr. Heather and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Dr. Heather. 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 wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I have read this consent 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.

Patient or Guardian's Signature :_________________________________ Date:____________

Massage Therapy: I hereby request and consent to the performance of Massage Therapy by Crystal Stewart, LMT, NMT and/or other licensed Massage Therapist who now or in the future treat me while employed by, working or associated with or serving as back-up for Healthy Spines Chiropractic, inc. I understand that Therapeutic massage is not a substitute for traditional medical treatment or medications and I understand and am informed that, as in the practice of medicine, in the practice of Massage Therapy there are some risks to treatment, including but not limited to bruising, soreness, exacerbation of undiscovered injury, inflammation, fractures, strokes, dislocations, strains and sprains. I do not expect the therapist to be able to anticipate and explain all risks and complications, and I therefore release Healthy Spines Chiropractic, inc. and the individual massage therapist from all liability concerning these injuries that may occur during the massage session. I understand the importance of informing my massage therapist of all medical conditions and medications, I am taking, and to let the massage therapist know about any changes to these. I have been given a chance to ask questions about the massage therapy session and my questions have been answered. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly. I understand that I or the massage therapist may terminate the session at anytime. I have read this consent 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. . I have clearance from my physician to receive massage therapy.

Patient or Guardian's Signature :_________________________________ Date:____________

CHILDREN & MINORS ONLY – Consent to Treat a Minor ***(completed by parent or guardian)***

I hereby authorize the doctor and whomever she may designate as assistants to examine and administer chiropractic care as deemed necessary to my child.

Patient or Guardian's Signature :_________________________________ Date:____________

HIPPA NOTICE OF PRIVACY PRACTICES

THE (OFFICE)

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.

The (OFFICE) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations:

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The (OFFICE)."

"It is our policy that we may provide a substitute health care provider, authorized by The (OFFICE) to provide assessment and/or treatment to our patients,
without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

"It is possible that you will be treated in an open treatment room. In the case that another patient is present during your treatment, personal health information may
be discussed between you and the provider. Should you wish to address issues that you may wish to remain confidential, a private room will be made available to you
upon your request."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations:

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to The (OFFICE) for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care
services received."

Workers' Compensation

Your health information may be disclosed as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for educational, marketing, or fundraising purposes, as described below:

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule
your appointment."

"Postcards are mailed as another method for reminding our patients of their appointments."

“As part of our responsibility to educate our patients about chiropractic and massage therapy we often send postcards, newsletters, e-mails, promotions, and personal
letters by mail.”
“We post pictures of our patients on our wall of Chiropractic Stars as well as voluntarily submitted testimonial letters.”
“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Healthy Spines Chiropractic sponsored fund-raising events.”

Change of Ownership

In the event that Healthy Spines Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

*You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Healthy Spines Chiropractic is not required to agree to the restriction that you requested.
*You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
*You have the right to inspect and copy your health information.
*You have a right to request that Healthy Spines Chiropractic amend your protected health information. Please be advised, however, that Healthy Spines Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
*You have a right to receive an accounting of disclosures of your protected health information made by Healthy Spines Chiropractic.
*You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

The Healthy Spines Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Healthy Spines Chiropractic is required by law to comply with this Notice.
Healthy Spines Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact (HIPPA OFFICER) by calling this office at 858-541-0505. If (HIPPA OFFICER) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Healthy Spines Chiropractic has handled your health information should be directed to (HIPPA OFFICER) by calling this office at 623-925-1386. If (HIPPA OFFICER) is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of May 26, 2020.
I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide Healthy Spines Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient’s Name

____ ______________
Patient’s Signature Date

____ ______________
Authorized Facility Signature Date