Elements Chiropractic Intake and History Form

Thank you for choosing our office. Please complete this form to help us serve you. All information will be kept confidential.

Patient Name_____ Date_____
Date of Birth_____ Sex_____ Phone #_____
Address_____ City_____ State/ZIP_____
E-mail_____
Employer_____ Occupation_____
Emergency Contact_____ Phone #_____
Height_____ Weight_____ Do you smoke?_____
Do you take medications?(please list)_____
Are you allergic to any medications?_____
Are you currently pregnant?_____
How did you hear about our office? (tv, radio, internet)_____

Please complete the following questions for each symptom that you are having

Problem #1_____ When did it start?_____
On a scale from 1-10 (10 being the worst) please rate your pain today
1 2 3 4 5 6 7 8 9 10
How often do you experience this symptom? (please circle one)
Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (0-25%)

Problem #2_____ When did it start?_____
On a scale from 1-10 (10 being the worst) please rate your pain today
1 2 3 4 5 6 7 8 9 10
How often do you experience this symptom? (please circle one)
Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (0-25%)

Problem #3_____ When did it start?_____
On a scale from 1-10 (10 being the worst) please rate your pain today
1 2 3 4 5 6 7 8 9 10
How often do you experience this symptom? (please circle one)
Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (0-25%)

Problem #4_____ When did it start?_____
On a scale from 1-10 (10 being the worst) please rate your pain today
1 2 3 4 5 6 7 8 9 10
How often do you experience this symptom? (please circle one)
Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (0-25%)

Have you seen any other providers for these symptoms?_____
Have you ever been to a chiropractor before today?_____

Past History

Please check all that apply to you or your immediate family (Mother, Father, Sibling)

	You	Family		You	Family
Stroke	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Cancer	☐	☐
Epilepsy/Seizures	☐	☐	Diabetes	☐	☐
Insomnia	☐	☐	Dizzy/Fainting	☐	☐
Aneurysm/Dissection	☐	☐	Arthritis	☐	☐
HIV/AIDS	☐	☐	Connective Tissue Disorder	☐	☐

Were you recently in an auto or work place injury?_____

Have you had any imaging performed within the last 5 years (x-ray, MRI, CT Scan)
_____

Who is your primary care physician?_____

All insurance claims are submitted to your insurance carrier as a service to you. We will submit your insurance claims electronically when possible. ***Your insurance policy is an agreement between you and your insurance company. We will do our best to inform you of your insurance benefits, but cannot guarantee payment or accuracy of the information obtained from the carrier's website. If your carrier denies or disputes a claim in whole or in part; or any claim that is not paid in 90 days will become your responsibility. Your will be balance billed for any portion that is not paid by your insurance company including deductibles, copays or amounts that are adjusted by your carrier, unless we have a contract stating otherwise.***
We will not accept claims currently in litigation. Financial arrangements can be made with our office.
I have read the above notice and agree to pay for any amount that is not covered by my insurance carrier. I authorize payment directly to Elements Chiropractic/Dr. Myers for all services rendered. I authorize the release of any information in regard to my examination, treatment and diagnosis (or that of my minor child) if requested by the insurance carrier or a third party payer for the purpose of processing my claim or to resolve an outstanding balance. I agree that a photocopy is as valid as the original.

Signature of Patient/Parent/Legal Guardian_____Date_____

Elements Chiropractic Clinic, PLC
Doctor Patient Relationship
Informed Consent

Chiropractic

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic healthcare seeks to restore health through natural means without the means of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

Analysis

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such Vertebral Subluxation Complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise your specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although doctors of chiropractic are experts in chiropractic diagnosis, the vertebral subluxation syndrome and complex, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent For Chiropractic Care

A patient, in coming to the doctor of chiropractic gives the doctor and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedure are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or healthcare, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses, connective tissue disorders, arterial dissection or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

Results

The purpose of chiropractic services is to promote natural health through the reduction of the Vertebral Subluxation Complex. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. In most cases, there is more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures will find relief through chiropractic care. In turn, conditions which do not respond to chiropractic care, may come under control or be helped through medicine or surgical procedures.

To The Patient:

Please discuss any questions or problems with the doctor before signing this statement of policy.
I have read, and understand the foregoing.

_____ _____

Signature Date

Acknowledgement and Consent of Notice of Privacy Practices
of
Elements Chiropractic Clinic, PLC
1125 E. Milham Ave. Suite B
, MI 49002

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to my protected health information. Towards that end Elements Chiropractic Clinic has established and presented to me a Notice of Privacy Practices. It is my understanding that this information may be used to:

• Conduct, plan, coordinate and direct my treatment and follow-up care among multiple healthcare providers who may be involved with my healthcare.
• Obtain payment from third party payers.
• Conduct routine office operations and healthcare requirements, assessments, licensing, and certification.
• This practice will not disclose non-routine information without my specific authorization.

A complete Notice of Privacy Practices has been made available to me to read, and remains available for public record at the front desk at the above mentioned practice. I understand that a copy will be provided to me upon my request at any time. I have been told that the notice is subject to change and I may contact Elements Chiropractic Clinic at any time for a revised copy of the Notices of Privacy Practices.
I understand that I may request in writing that Elements Chiropractic Clinic restrict how my private health information is used or disclosed and that they are not obligated to oblige my request for restricted disclosure, but if agreed to; they may not violate that agreement.
Dr. Brett A. Myers, D.C., his associates and support staff acting on his behalf, have assured me that Elements Chiropractic Clinic will always use professional judgement with my best interest in mind and will disclose only the necessary information to achieve the intended purpose.
By my signature below I acknowledge that the Notice of Privacy Practices has been presented for my inspection and I understand that certain routine protected health information will be released as noted above, and specific non-routine disclosures will require my specific written authorization.

_____
Patients Name

_____ _____
Authorized Signature Date

_____
Relation To Patient

Office Use Only
An attempt was made to obtain the patients signature on this document to provide the necessary authorization for disclosure of PHI. We were unable to obtain a signature for the reason stated below:
Staff Initials:_____ Date:_____

Elements Chiropractic Clinic, PLC will charge a fee of $20.00 for No Show/No Call missed appointments.

This fee will be due at your next appointment and will be in addition to any other co-pays and/or deductibles that apply to your policy.

Patient's Name:_____ Date:_____

Authorized Signature:_____

Relationship to Patient:_____