ChiroAdvantage Health Questionnaire

File #: _____

Name_____ **Home Phone**_____

Address _____ **Cell Phone**_____

City_____ **State**_____ **Zip Code**_____ **Date of Birth**____/____/____ **Male/Female**

Age_____**SSN**_____ **Email**_____

Occupation_____ **Marital Status: M W D S Spouse's Name**_____

# of Children_____ **Children's Names**_____

STOP **Are you Medicare eligible?** ☐ Yes ☐ No

1. Many patients are referred to our office by a family members or friends. Who or what made you decide to visit our office?

_____

2. Science tells us your spine, like your teeth, need to be cared for regularly. How often do you get adjusted by a chiropractor?
☐ Frequently ☐ Only when you hurt ☐ 1 x per month ☐ Never

3. When was your last complete spinal examination, including X-rays?_____ ☐ Never

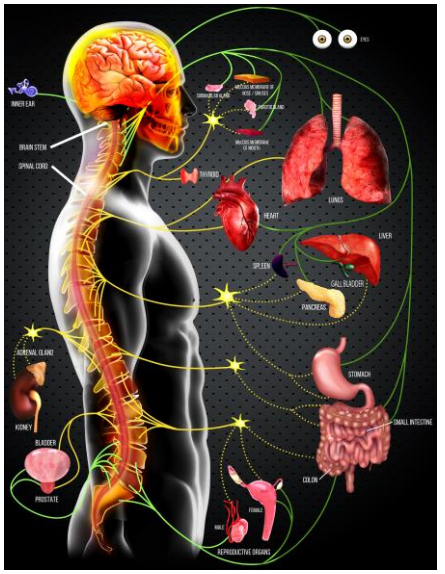
4. Do you know if you have: ☐ Spinal curvature ☐ Spinal arthritis ☐ Inherited spinal problem

5. Over time, spinal misalignments will cause arthritis & degeneration, which results in grinding or cracking to be heard when you move your neck or back, as well as a loss of Nerve Health. Do you hear these sounds when you move your head or neck? ☐ Yes ☐ No

6. If your spine is out of alignment for a long time it can it can make you feel like you need to twist, stretch, or crack your neck or back. Do you feel the need to crack or pop your neck or back? ☐ Yes ☐ No

7. Poor posture leads to poor health and early death. How would you rate your posture?
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress can cause your spine to misalign and accelerate spinal damage. Rate your stress level over the last 3 months. Poor 1 2 3 4 5 6 7 8 9 10 Excellent



9. Please circle or list any health symptoms or health complaints you are experiencing.

Neck pain L/R	Headaches	Heart Disease	Thyroid
Mid-back pain	Asthma	Cancer	Allergies:_____
Low-back pain	Diabetes I/II	Constipation	_____
Arm pain L/R	Immune Issues	Menstrual pain	Numbness/Tingling:_____
Leg Pain L/R	Digestive Issues	Hormone Imbalance	_____

10. Prescription medications cause various side effects, hides the severity of health problems, and could hinder the body's ability to heal. What medications are you currently taking?

1._____2._____3._____

4._____5._____6._____

11. Please list any surgeries you have had._____

12. Do you smoke? ☐ Yes ☐ No

13. Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant? ☐ Yes ☐ No

14. Daily traumas, auto accidents, and work injuries cause misalignments of the spinal bones and serious problems. When was your most recent injury? At Home:_____Car Accident_____Slip or Fall_____

15. Improper sleeping positions can cause spinal misalignment and spinal damage. What sleeping position do you sleep in a majority of the time?
☐ Back ☐ Stomach ☐ L Side ☐ R Side

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often

17. Please list vitamins/supplements you take:_____

The above information is true and accurate to the best of my knowledge.

Patient Signature (parent/guardian):_____ Date:_____

12101 Bee Caves Road, Suite 5B, Bee Cave, TX 78738
612-615-8869 ChiroAdvantage@yahoo.com www.ChiroAdvantage.com

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided, so you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy, and art, which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or instrument where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual finding, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; e.g. muscle spasms, stiffness, rib fracture, headache, and dizziness.

All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name Signature Date

Consent to evaluate and adjust a minor child

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

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform or refer out for an x-ray evaluation (if necessary). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature Date

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CHIRO ADVANTAGE
If you want different...

This is to acknowledge my approval to allow Dr. Scott to take my picture for the sole use of patient file identification only. **This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.**

Patient Signature:_____

Date:_____

Our purpose is to educate and adjust families toward optimal health using natural chiropractic care.

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Patient Name: _____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients wanting to use insurance, this would include charges not reimbursed by my insurance company and accept any responsibility for charges which may not be approved.

Note: If you want to use your insurance benefits, you have that right and will receive a statement upon request at the end of each month, so you may bill your insurance company or HSA/FSA directly.

I understand this office will require payment from me for any services provided, which are either covered or not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month, and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs of disbursements of the action.

I have read this document and understand my obligations for payment for care regardless whether my health insurance plan rebuses me for service rendered or not.

_____

Signature (Patient or Parent/Gradian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Scott to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____

Signature (Patient or Parent/Gradian of Patient) Date

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CHIRO ADVANTAGE
If you want different...

Notice of Privacy Practices

This notice describes how health information about you is stored, may be used, and or disclosed.

How We Store Your Information: Patient information is stored here in the office on a secure server with no outside access. X-Rays images (if taken) are also stored on the server and the hard copies of your file and X-Rays are stored here in our office. All storage is secure and meets or exceeds HIPPA requirements and regulations.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions, and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our patients to anyone who receives our services. Know that all patient information is considered confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care or to provide you with health care or services which may require communication between ChiroAdvantage, Inc. and health care providers, insurance companies, and other providers necessary to: Verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, and insurance.

No Patients information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will ever be used without patient's express written advance permission.

Print Patient Name _____

Signature _____ Date _____

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