APPLICATION FOR CARE AT INSPIRE CHIROPRACTIC

1. Today's Date: HR #:

2. PATIENT DEMOGRAPHICS

Name: Birthdate: Gender: ○ M ○ F

Address: Apt./Unit #: City: State: Zip Code:

Home Phone: Work Phone: Mobile Phone:

E-mail Address: Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Social Security #: Driver's License #:

Employer: Occupation:

Spouse's Name: Spouse's Employer:

Number of children and ages:

Emergency Contact Name: Phone Number: Relationship:

HISTORY OF COMPLAINT

3. Please identify the condition(s) that brought you to this office:

Primary: Secondary:

Third: Fourth:

4. On a scale of 0 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by marking the number:

	0	1	2	3	4	5	6	7	8	9	10
Primary or chief complaint is:											
Second complaint is:											
Third complaint is:											
Fourth complaint is:											

5. When did the problem(s) begin?

When is the problem at its worst?
○ AM ○ PM ○ Mid-day ○ Late PM

How long does it last?
○ It is constant OR ○ I experience it on and off during the day OR
○ It comes and goes throughout the week

How did the injury happen?

Condition(s) ever been treated by anyone in the past?
○ Yes ○ No

If yes, when?

by whom?

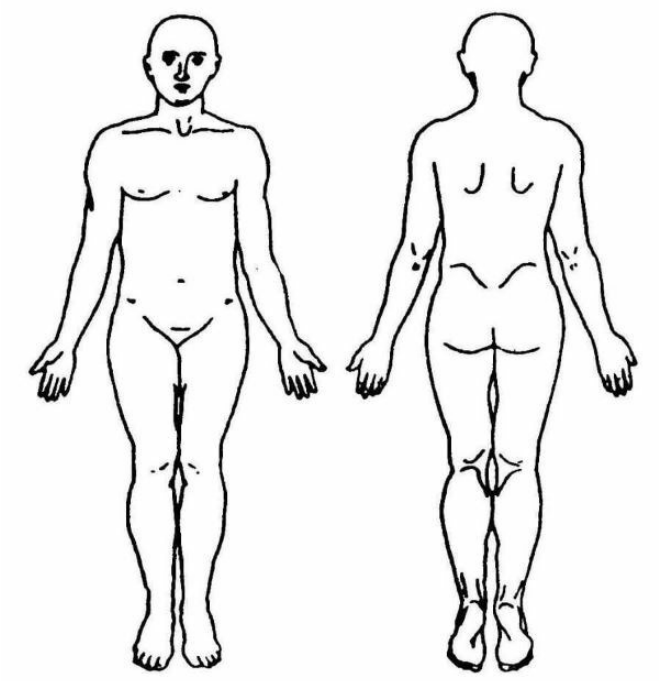
How long were you under care?

Name of previous chiropractor:

☐ N/A

6. PLEASE MARK the areas on the body diagram with the following legends to describe your symptoms:

0 - Radiating 1 - Burning 2 - Dull 3 - Aching 4 - Numbness 5 - Sharp/Stabbing 6 - Tingling



If not a pain based complaint, specify:

_____

7. What relieves your symptoms?

_____

What makes your symptoms feel worse?

_____

8.

	LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
1			
2			
3			

If activity is not restricted, specify:

_____

9. Is your problem the result of ANY type of accident?
○ Yes ○ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

10. Have you suffered with any of this or a similar problem in the past?

- ○ Yes
- ○ No

11. If yes:

How many times? _____

When was the last episode? _____

How did the injury happen?

_____

12. Other forms of treatment tried:

- ○ Yes
- ○ No

13. If yes:

Please state what type of treatment:

_____

Who provided it? _____

How long ago? _____

What were the results.

○ Favorable ○ Unfavorable

Please explain:

_____

14. Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

_____

_____

15. If you have ever been diagnosed with any of the following conditions, please indicate with:

	Past	Currently	Never
Broken Bone			
Dislocations			
Tumors			
Rheumatoid Arthritis			
Fracture			
Disability			
Cancer			
Heart Attack			
Osteo Arthritis			
Diabetes			
Cerebral Vascular			
Other serious conditions			

Other:

_____

16. PLEASE IDENTIFY ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	How long ago	Type of Care	Provided by whom
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

If not applicable, specify:

_____

FAMILY HISTORY

17. Does anyone in your family suffer with the same condition(s)?

- ○ Yes
- ○ No

18. If yes, whom?

- ☐ grandmother
- ☐ grandfather
- ☐ mother
- ☐ father
- ☐ sister(s)
- ☐ brother(s)
- ☐ son(s)
- ☐ daughter(s)

19. Have they ever been treated for their condition?

- ○ Yes
- ○ No
- ○ I don't know

20. Any other hereditary conditions the doctor should be aware of?

- ○ Yes
- ○ No

If yes, specify:

_____

SOCIAL HISTORY

21. Smoking:

○ cigars ○ pipe ○ cigarettes ○ none

How often?

○ Daily ○ Weekends ○ Occasionally ○ Never

Alcoholic Beverage: consumption occurs:

○ Daily ○ Weekends ○ Occasionally ○ Never

Recreational Drug use:

○ Daily ○ Weekends ○ Occasionally ○ Never

Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See Activities of Life form)

_____

I hereby authorize payment to be made directly to Inspire Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Inspire Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

_____ _____

Signature Date

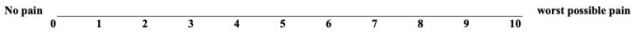
Doctor's Signature

_____ _____

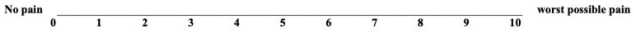
Signature Date

22. Patient Name: Date of Birth:

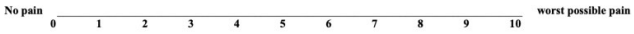
23. 1 – What is your pain RIGHT NOW? If not a pain based complaint, circle 0.



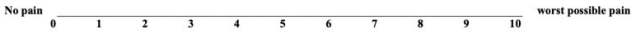
24. 2 – What is your TYPICAL or AVERAGE pain? If not a pain based complaint, circle 0.



25. 3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)? If not a pain based complaint, circle 0.



26. 4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)? If not a pain based complaint, circle 0.



27. OTHER COMMENTS:

Examiner Signature

Signature Date

28. Patient's Name: HR #: Date:

29. Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Carry Children/Groceries				
Sit to Stand				
Climb Stairs				
Pet Care				
Extended Computer Use				
Lift Children/Groceries				
Read/Concentrate				
Getting Dressed				
Shaving				
Sexual Activities				
Sleep				
Static Sitting				
Static Standing				
Yard work				
Walking				
Washing/Bathing				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Driving				
Other				

If other, specify:

_____

30. List Prescription & Non-Prescription drugs you take:

	Medication Name	Dosage	Frequency	Reason for Use
1				
2				
3				

If other, specify:

Patient or Authorized Person's Signature

Signature Date

Doctor's Signature

Signature Date

31.

	Past	Currently	Never
Headache			
Neck Pain			
Jaw Pain, TMJ			
Shoulder Pain			
Upper Back Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Back Curvature			
Scoliosis			
Numb/Tingling arms, hands, fingers			
Numb/Tingling legs, feet, toes			
Pregnant (Now)			
Frequent Colds/Flu			
Convulsions/Epilepsy			
Tremors			
Chest Pain			

Pain w/Cough/Sneeze			
Foot or Knee Problems _			
Sinus/Drainage Problem			
Swollen/Painful Joints			
Skin Problems			
Dizziness			
Loss of Balance			
Fainting			
Double Vision			
Blurred Vision			
Ringing in Ears			
Hearing Loss			
Depression			
Irritable			
Mood Changes			
ADD/ADHD			
Allergies			
Prostate Problems			
Impotence/Sexual Dysfun			
Digestive Problems			
Colon Trouble			
Diarrhea/Constipation			
Menopausal Problems			
Menstrual Problem			
PMS			
Bed Wetting			
Learning Disabilty			
Eating Disorder			
Trouble Sleeping			
Ulcers			
Heartburn			
Heart Problem			
High Blood Pressure			

Low Blood Pressure			
Asthma			
Difficulty Breathing			
Lung Problems			
Kidney Trouble			
Gall Bladder Trouble			
Liver Trouble			
Hepatitis (A,B,C)			

Patient or Authorized Person's Signature

Signature Date

Doctor's Signature

Signature Date

PATIENT'S NAME: _____ HR#: _____ DATE: _____

INSPIRE CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Inspire Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

Inspire Chiropractic **Dr. Josh Hasty**
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www.goinspirechiropractic.com info@goinspirechiropractic.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: **_____ - retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Inspire Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office 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 past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Inspire Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse Name: _____
- ☐ Significant Other Name: _____
- ☐ Parent/Legal Guardian Name: _____
- ☐ Child(ren) Name(s): _____
- ☐ Any Specified Person Name: _____
- ☐ Information is not to be discussed with or released to anyone.

Restrictions:

- ☐ No Restrictions
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ☐ my home ☐ my work ☐ my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

I understand I may terminate this consent at any time by giving written notice to Inspire Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____