

Patient Name _____ DOB _____ Date _____

CHILDREN & PREGNANCY

How many children do you have? _____ Are you currently pregnant? No. Yes, I am due _____

Children's ages? _____ Number of past pregnancies?

Children's health concerns? _____ Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues
<small>(Constipation/Diarrhea/GERO/IBS)</small> | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Endocrine Issues | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> (Thyroid) | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Reproductive Issues | <input type="checkbox"/> _____ |

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (List)

MEDICATIONS (List)

SUPPLEMENTS (List)



Patient Name _____ DOB _____ Date _____

Have you experienced chiropractic care before? Yes/No If yes, was it a positive/negative/neutral experience?	
What percent of your diet consists of fruits and vegetables?	_____ %
How many ounces of water do you consume on average, daily?	_____ ounces
How much alcohol do you consume? None / Once in a while / Weekly / Daily / Multiple times per day	
Do you smoke? None / Once in a while / Weekly / Daily / Multiple times per day	
Do you exercise? None / Once in a while / Weekly / Daily / Multiple times per day	
Are you healthier now than you were 5 years ago?	
List any surgeries:	
Any family history of? Diabetes /Heart Disease /Cancer /Rheumatoid Arthritis /High Blood Pressure	
When do you generally feel your worst? A.M / Noon / P.M.	
Are you committed to your health? Not	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 Extremely

ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT

I hereby consent to a chiropractic evaluation and examination, x-ray(s), chiropractic treatment(s), decompression, k-laser, supplements, healthy lifestyle information (books, CD's, DVD's, etc.), or activities of daily living information rendered to the client which our doctors may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Stanlick Chiropractic. I hereby authorize the above named doctor(s) to release information requested on this form, and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I know I am responsible for payment of my account, and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductible, coinsurances and co-pays are my responsibility to pay.

TERMS

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1.5% per month (annual percentage rate 18%) of unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

NOTICE OF PRIVACY PRACTICES

The federal government has passed the Health Insurance Portability and Accountability Act ("HIPAA") to protect your Personal Health Information ("PHI"). HIPAA took effect on April 14, 2003. As a healthcare provider, implementation of, and compliance with, HIPAA is not optional for Stanlick Chiropractic.

Sign below indicating that you have had the opportunity to receive a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will need an Acknowledgment Form signed by you on behalf of the patient.

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of: Stanlick Chiropractic and all my questions have been answered to my satisfaction in language that I can understand.

Signature _____ Date _____

Relationship _____ DOB _____

Witness _____

CONSENT FOR CHIROPRACTIC CARE

I hereby request that Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C. provide chiropractic services for me (or my minor child, whose name appears below). I understand that the care is to be provided by Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Garrett Webb, D.C., Jonathan Sheridan, D.C. and/or designated assistant. Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C has discussed my care with me, and I understand that:

1. **The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.**
2. **Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis of medical conditions is not a primary goal. However, I will be informed of abnormal findings.**
3. **Chiropractors do not give medical advice, nor do they discourage me from receiving medical advice. If deemed advisable Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C. will refer me for medical services with all possible diligence.**
4. **Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Garrett Webb, D.C., and/or Jonathan Sheridan, D.C uses only chiropractic methods that are taught in accredited colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.**
5. **Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.**
6. **Although the risks are very minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.**
7. **Because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.**
8. **I am an active participant in my chiropractic care, and I am therefore invited to ask any questions or express any concerns that I may have.**
9. **I am free to withdraw my consent and discontinue care at any time.**

- Signing below on behalf of self
- Signing below on behalf of minor

CONSENT TO EVALUATE AND TREAT A MINOR

ONLY pertains if filled out on behalf of minor -*Skip to signature if not signing on behalf of minor

By signing below, I, _____ being the parent/legal guardian of _____ do hereby grant permission to the treating staff doctor to perform chiropractic services to the minor listed above.

I have read the above statements and understand Stanlick Chiropractic’s objectives pertaining to my care in this office.

Signature _____ Date _____

Witness _____ Date _____

Witness (printed) _____