Hands On Health Chiropractic

www.handsonhealthnj.com

Name _____ Date _____

Address _____ City _____State _____ Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____

Email address _____ ←**Please print clearly**

(Very, very important! For office closings, office newsletters, receipts, essential notifications, schedule changes, bulletins, etc…)

Date of Birth _____ Age _____ SSN _____ Spouse/Partner's Name _____

No. of Children _____ Occupation _____ Employer _____

We are a 100% referral office, whom do we have the pleasure of thanking for referring you? _____

Chiropractic is not about a treatment or cure for disease Chiropractic is for the removal of interference to the nervous system (subluxations) and restoration of function and communication within the body so that your body may express its fullest potential for life and healing.

In this office, our only purpose is to check for subluxations, subluxations are painless and people should be checked for subluxations from birth, when were you last checked for subluxations? _____

Would you like your family to be checked for subluxations? Y N

Subluxations cause poor sleep, low energy, reduced healing capacity, and much more, what are you currently experiencing?

_____

Have you seen any other doctor's about this? Y N If yes, list outcome/treatment:

_____

Have you ever had any Surgeries/Hospitalizations? If Yes, list:_____

Have you ever had any Traumas/Falls/Accidents? If Yes, list:_____

Even when properly prescribed, medications are the leading cause of death in America and a leading cause of subluxation, please list all medications you are taking: (use the back of this page if necessary)

_____

Improper lifestyle habits contribute to subluxations:

Do You Exercise? Y N If yes, please describe:_____

Smoker? Y / N Alcohol? Y / N If yes, Social (Fewer then 2 daily) Heavy (2 or more daily)

List the foods you eat daily and summary of your diet habits:

_____

_____

Unable to handle everyday stress is another contributor to subluxation: *Please rate from 1 (bliss) to 10 (nervous breakdown)*

Work _____ Personal life _____ Health _____ General worry _____

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Wellness Survey

- Reason for seeking Chiropractic Care today?

- What does the term *Wellness* or *Being Healthy* mean to you?

- On a scale from 1-10 how healthy are you right now?

- Why have you chosen this number to indicate your current level of *Health*?

- Do you feel that you could be *Healthier?*

- How do you think Chiropractic can help you reach your personal Health Goals?

- What do you think that a Chiropractor's role is in promoting *Better Health*?

- List any and all proactive health activities that you regularly integrate into your day to day routine.

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Life Style History

History of Physical Stress, Trauma or Challenges

MVA: _____ Dates: _____ Type of Collision: _____

Speed: _____ Falls: _____ Broken bones: _____

Sprain/Strain: _____ Surgeries: _____

Lifting Injuries: _____ Rape/Violations: _____

Others: _____

History of Chemical Stress, Trauma or Challenges

Prescription Drugs: _____

Over the Counter Drugs: _____

Exposure to toxic chemicals: _____

Anesthesia: _____ General: _____ Local: _____

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History of Emotional stress, Trauma or Challenges

Divorce: _____ Separation: _____ Relationship: _____

Job situation: _____ Emotional abuses: _____

Others: _____

Current Life Style

Nutrition	Fluid Intake	Exercise	Sleep/Rest	Work Satisfaction	Vacation	Sexual Rapport	Family Dynamic	Play/Fun/ Hobbies

Others: _____

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Case History for Pregnancy

Name _____Date of Birth_____ Today's Date _____

Allergies _____

Do you smoke? _____ (If no did you ever smoke)?_____ How Long? _____

Do you drink? None Social (Fewer then 2 daily) Heavy (2 or more daily)

List the foods you eat daily and summary of your diet habits:

What type of exercises do you do?

Age at last menstrual cycle? Length of regular menstrual cycle?

Are your cycles regular? Always Most of the time Never

Date of your last menstrual cycle: Was it normal?

Date of last x-rays if any? Why and by whom?

Have you had any previous pregnancies? Explain

Have you had past cesareans? Yes No How many?

Have you had a previous D&C? Yes No How many and dates?

Do you have any of the following? Diabetes, Asthma, Rh negative blood, Other chronic problems (Please list):

Have you taken birth control pills? Yes No Type:

Have you used an IUD? Yes No Date of removal:

Did you have any health problems during previous pregnancies? Yes No Explain

Have you ever received chiropractic care? Yes No Dr's. Name:

Name of your obstetrician? Nurse/Midwife?

Where do you plan to have your baby?

What symptoms of pregnancy have you already experienced?

List any additional comments/concerns:

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Philosophical Agreement

Hands on Health Chiropractic exists to make a positive contribution in your Life, by assisting you to heal naturally and to enjoy abundant health and wellbeing. **The Practice of Chiropractic** is based on ageless principles governing health and healing. They are briefly explained below so that you may understand how Chiropractic can help you.

Life Force is the sole difference between life and death. From the moment of conception until your last breath, Life Force is the essence that sustains you. You can live for some time without food, water, sleep, exercise and even air, yet you cannot live an instant without Life Force. Life Force is the essential ingredient in health and healing. It is the power that runs and heals your body.

Healing is the creation of new cells to replace old, sick or damaged ones. Cellular replacement is how your body heals and repairs naturally. When new healthy cells are created regularly you stay well and healthy. Life Force is generated by the brain and flows through your spinal cord and nerve network to coordinate every tissue cell of your body.

The Nerve System is the medium used for the transfer of vital information essential for everything from healing to body functions, emotions, creativity, performance and self-expression. Your Nerve System is your link between the inner and outer world. It consists of the brain, the spinal cord, the nerves and dazzling array of neurotransmitters. The extent of the Nerve System is such that your Nerve System and **Immune System** are in fact one; therefore a Nerve System at ease rather than stressed or tense, leads to a stronger, better functioning Immune Response and your body performing at its best.

Blockages and interferences to your Nerve System develop throughout life from physical, emotional or chemical stress, which interferes with your physiology. With time, dis-ease, mal-function, symptoms, sickness and disease manifest. These symptoms are the effects of being disconnected from yourself and your Life Force.

A **free flow** of brain to body communication enhances your ability to adapt, heal, repair and live. When messages from your brain travel freely to all parts of your body, you express and experience Life fully. Healing, wellbeing, increased performance and greater personal expression are the natural byproducts.

Chiropractic adjustments free Life Force and the flow of messages between the brain and body, by removing interference to the Nerve System. It allows every individual to heal, repair and experience more vitality. Due to a greater Life Force flow, any and all areas of a person's life can improve. In some individuals, physical, emotional and/or mental challenges may clear up quickly; in others the process is slower or partial. The power of the adjustment is remarkable.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. **Chiropractic specializes in the expression of life, health, wellness, healing and wellbeing.** Medicine specializes in the diagnosis and treatment of symptoms, sickness and disease. One is not exclusive of the other; both are separate and distinct professions. Rather than diagnose, treat or prognose any physical, mental or emotional ailments which is the practice of Medicine, we free Life Force through adjustments. We share information and impart knowledge about natural healing, health, wellness and wellbeing, which is the practice of Chiropractic. Our primary goal is your health, healing process and wellbeing. We are here to support you.

I (We),_____&_____ the undersigned, have completely read and understood the above statement and choose to receive care at Hands on Health.

Signed _____ Date _____

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Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Hands on Health to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

I give permission to Hands on Health to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.

If Hands on Health contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give permission to Hands on Health to use my name on a welcome board, referral board, and birthday board.

I give permission to Hands on Health to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.

I give permission to Hands on Health to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.

By signing this form you are giving Hands on Health permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at the Hands on Health more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of your care at Hands on Health plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Hands on Health. The written notice must contain the following information:

Your name, Social Security number, and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and your signature

The revocation is not effective until it is received by Hands on Health.

This AUTHORIZATION is requested by Hands on Health for its own use / disclosure of PHI. *(Minimum necessary standards apply.)*

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I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, the Hands on Health will provide care, however, it will not be possible for Hands on Health to file third party billing on my behalf and I will be responsible for: 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Hands on Health will be unable to contact me 3) all contact with Hands On Health regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, with boundaries, the Protected Health Information to be used / disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ D.O.B.: _____ / _____ / _____

My Name (Print): _____

My Signature: _____Today's Date: _____ / _____ / _____

Name of Personal Representative (If someone other than yourself is designated to act on your behalf)

Name (Print): _____

Signature of Personal Representative: _____

Description of Representative's Authority To Act On your Behalf: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The client refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____

Employee Name *Today's Date*

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This **Practice Member Agreement** is made and entered into by and between the named client and provider. Whereas, patient desires to receive services from this health care provider and therefore desires to assign certain rights and benefits to provider it is hereby agreed:

A. When we accept you as a client it's important that you understand the objectives of our care. **Chiropractors provide a unique service that no other healthcare providers offer.** Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system. The purpose of chiropractic care, in this office, is not to treat disease, suppress symptoms, perform surgery or prescribe medications but rather to improve the health and function of your spine and nerve system to help your body function at its optimum health and healing potential. Our primary objective is to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible, using specialized techniques called "chiropractic or spinal adjustments" over a period of time. It is not our objective to prescribe medication, medically diagnose or treat disease. If you desire diagnosis or treatment for a disease or condition or advice on taking or stopping medications, we recommend you consult a healthcare provider who specializes in that area.

B. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of physical treatment and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or his/her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named, including those working at the clinic or office listed or any other office or clinic.

C. 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, fracture, disc injury, apoplexy, stroke, dislocation and sprain. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels appropriate at the time, based upon the facts then known, to be in my best interests. If unusual findings are discovered during the course of our chiropractic examination(s) they will be discussed with me. I may then decide whether I wish to investigate them further and discuss my healthcare options with other health professionals with the full cooperation of the listed Chiropractic Practice.

D. I recognize that this agreement is not a guarantee of clinical results. There is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program. Any balance due for services are due regardless of results. This agreement is non-transferable and constitutes the complete agreement between client and provider. No other chiropractic facilities are covered by this agreement. This agreement does not constitute insurance and as such provider makes no promises to treat new conditions under this agreement.

E. Patient hereby authorizes this provider to release and permit the examination and/or copying of any of patient's medical records, x-rays, laboratory reports and the results of all tests of any kind or character to such persons as provider deems appropriate.

F. The assignments and agreements contained in this document may not be revoked by patient without the express consent of the provider. We reserve the right to cancel agreement at any time for any reason. This agreement is non-transferable and non-refundable.

I understand the purpose of chiropractic care as explained above I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic care in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic care offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

_____

Member Signature Date Member Signature Date

_____

Member Signature Date Staff Signature Date

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