



Health Profile

Name _____ Date ____/____/____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Date of Birth ____/____/____

Email Address _____

For confirming appointments, would you prefer? EMAIL or TEXT

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

Who may we thank for referring you? _____

Main Health Concern History

Health concerns: In order of Severity	Rate of Severity 1=Mild 10= Unbearable	How long have you had this?	Did this start with an injury?	Have you had this Before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

- Please check all that apply when describing the pain? Sharp Soreness Throbbing Tingling Dull Stiffness Spasm Burning Ache Weakness Numbness Shooting
- Does the pain travel anywhere else? Yes No Describe _____
- How often is this Present? Constant(81-100%) Frequent(51-80%) Occasional(26-50%) Intermittent(25% or less)
- Since it started, has the pain gotten better, worse, or stayed the same? _____
- What makes your health concern worse? Nothing Walking Standing Sitting Exercise(moving) Laying down Other
- Have you seen anyone else for this health concern(Chiropractor, Medical Doctor, etc.) If so, who? _____
- Please list all medications, including Vitamins/Supplements, you are taking and for what? _____

- Please list any broken bones, surgeries, or hospitalization you have had and when: _____

- Please list any auto accidents or major slips/falls/traumas you have been involved in: _____

10. Spinal health is especially important during pregnancy; **any chance** that you are pregnant? **Yes or No**

PAST HISTORY

1. Have you suffered with any of this or similar problem in the past ___ No ___ Yes If yes, how many times?
___ When was the last episode? _____ How did the injury happen? _____
2. Other forms of treatment tried: ___ No ___ Yes If yes, what type of treatment? _____
Who provided it? _____ How long ago? _____ What were the results ___ Favorable
___ Unfavorable; Please explain _____
3. 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 _____
4. If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never** have had:
___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Arthritis ___ Cerebral Vascular ___ Other _____

SOCIAL HISTORY

1. **Smoking:** ___ Cigars ___ Pipe ___ Cigarettes How often? Daily, Weekends, Occasionally, Never
2. **Alcoholic Beverages:** Consumption occurs: Daily, Weekends, Occasionally, Never
3. **Recreational Drug Use:** Daily, Weekends, Occasionally, Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same conditions? ___ No ___ Yes **If yes, whome:** ___ Grandmother
___ Grandfather ___ Mother ___ Father ___ Sister(s) ___ Brother(s) ___ Son(s) ___ Daughter(s)
2. Have they ever been treated for their condition? ___ Yes ___ No ___ I don't know
3. Any other hereditary conditions the doctor should be aware of? ___ No ___ Yes

On a scale of 1 to 10 with 10 being the highest, rate your commitment in helping us solve this problem: _____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW WRITTEN CONSENT FOR A CHILD
NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. WILLIAM RAMOS AND ANY AND ALL FOUNDATION CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES,
RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY
AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY FOUNDATION CHIROPRACTIC.

DATE

GUARDIAN SIGNATURE

WITNESS SIGNATURE

GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

(Signature)

(Date)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE

DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

DATE

RELATIONSHIP TO MINOR/CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE