INTEGRATED
HEALTH & INJURY CENTER

Today's Date: _____

ABOUT YOU:

Patient Name: _____
What you prefer to be called: _____ ☐ Male ☐ Female
Birth Date: _____ Age: _____ SS# _____
Mailing Address: _____
_____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ Email Address: _____
Referred By: _____
Employer: _____
Employer's Address: _____
_____
Occupation: _____
Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____
Do you have children? ☐ Yes ☐ No How many? _____

IN EVENT OF AN EMERGENCY:

Who should we contact? _____
Relation: _____ Phone Number: _____
Who is your Medical Doctor? _____
Phone number: _____ Office location: _____

INSURANCE INFORMATION:

Company Name: _____
Address: _____
_____
Phone Number: _____ Insured's ID _____
Group Number (Plan, Local, or Policy): _____
Insured's Name: _____

ACCOUNT INFORMATION:

Person ultimately responsible for account

Name: _____
Relation: _____
Billing Address: _____
_____
Social Security Number: _____ Driver's License Number: _____ State: _____
Phone Number _____

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HEALTH HISTORY:

Are you taking any medications, including vitamins and over the counter? ☐ No If Yes, list below:

_____

Do you have or have ever had any of the following diseases or conditions? Circle Yes or No

Y/N	Hear Attack	Y/N	Lower Back Problems	Y/N	Artificial valves
Y/N	Stroke	Y/N	Heart surgery	Y/N	Hepatitis
Y/N	Congenital Heart Defect	Y/N	Pacemaker	Y/N	Cancer
Y/N	Alcohol Abuse	Y/N	Mitral Valve Prolapse	Y/N	Anemia
Y/N	Drug Abuse	Y/N	STD/STI	Y/N	Ulcers/Colitis
Y/N	HIV+/AIDS	Y/N	Shingles	Y/N	Asthma
Y/N	Frequent Neck Pain	Y/N	Emphysema	Y/N	Chemotherapy
Y/N	High/Low Blood Pressure	Y/N	Glaucoma	Y/N	Arthritis
Y/N	Severe/Frequent Headaches	Y/N	Psychiatric Problems	Y/N	Heart Murmur
Y/N	Fainting	Y/N	Kidney Problems	Y/N	Tuberculosis
Y/N	Seizures	Y/N	Epilepsy	Y/N	Sinus Problems
Y/N	Difficulty Breathing	Y/N	Artificial Bones/Joints	Y/N	Diabetes

Please list any other serious medical condition you have or ever had: _____

_____

Please list anything that you may be allergic to: _____

List any previous surgeries/treatments with dates: _____

List any past serious accidents with dates: (Automobile, Worker's Comp, Slip and Fall, etc.)_____

_____

FAMILY HEALTH HISTORY: (High blood pressure, Heart conditions, Diabetes, Cancer, etc.)_____

_____

Do you take vitamins or supplements? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No SINCE: _____/_____/_____

Do you smoke? ☐ Yes ☐ NO Packs Per Day? _____ How Long?_____

Are you taking birth control? ☐ Yes ☐ NO Name:_____

Are you pregnant? ☐ YES ☐ NO / How far along? _____ Nursing? ☐ YES ☐ NO

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient.
- Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account.

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- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I authorize payment from any insurance carrier directly to this office with understanding that all will be credited to my account upon receipt. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend my care and treatment, all fees for professional service rendered unto me would be immediately due and payable. .In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

SIGNATURE: _____ DATE:____/_____/_____

☐ Patient ☐ Parent or Guardian ☐ Spouse

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MOTOR VEHICLE COLLISION & PERSONAL INJURY QUESTIONAIRE

Patient Name: _____ Date: _____

Date of accident: _____

- Were you the driver: □ Driver □ Passenger □ Pedestrian
- If you were the passenger, were you in the: □ Front seat □ Right rear seat □ Left rear seat
- Was the impact from: □ the front □ the rear □ the left side □ the right side
- Were you wearing your seat belt? □ Yes □ No
- Did you go to the hospital? □ Yes □ No If yes, how did you get there? □ Ambulance □ Other
  If yes, when? □ Day of accident □ Next Day □ Other: _____

Did you have x-rays taken at the hospital: □ Yes □ No
Were you given medication? □ Yes □ No
In your own words, describe the accident:

_____
_____
_____
_____

What are your injuries?

_____
_____

Injuries began when? _____

Please mark the quality of the complaint pain:

□ Dull □ Aching □ Shooting □ Throbbing □ Deep □ Nagging □ Stabbing □ Numbness
□ Tingling □ Stiffness □ Other: _____

Is your complaint: □ getting better □ getting worse □ unchanged since it began?

What type of work do you do? _____

What are your job requirements? _____

Have you lost any days of work due to your injury? □ Yes □ No

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, performed on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name Printed: _____

Patient (Parent/Guardian) Signature _____ Date_____

CONSENT TO TREAT A MINOR

If patient is under the age of 18 the guardian needs to sign below: (PLEASE, circle one)

I, _____, am the (mother, father, guardian, grandparent) to the patient and acknowledge that I am giving permission for the minor listed below to be treated under chiropractic care.

Patient Name Printed: _____

Parent/Guardian Signature _____ Date_____

Witness Signature _____ Date _____

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HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

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

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name	DOB: (mm/dd/yy)
Signed (Patient or Legal Representative for Patient)	Date:
Legal Representative's Relationship to Patient	Date:

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AUTHORIZATION FOR RELEASE OF RECORDS

To: _____

_____

I hereby authorize and request that you release any and all health records and diagnostic reports in your possession concerning the undersigned.

To: Integrated Health and Injury

_____

_____

_____

Patient Name: _____

Date of Injury/Service: _____

Date of Birth: _____

Patient Signature: _____

Date: _____