GENERAL INFORMATION

Name: _____ Date of Birth: ____/_____/____ Age: _____

Postal Address _____ Gender: ◯ Male ◯ Female

City: _____ Postal Code _____ Home Phone: _____

Social Security: XXX-XX- _____ Cell Phone: _____

Occupation: _____ Marital Status: _____

Spouse Name: _____ Spouse Occupation: _____

How did you hear about Dynamics Chiropractic Center? If someone referred you, what is their name?

_____

Emergency Name and Number: _____ Phone _____

EXTENDED HEALTH CARE COVERAGE

_____ _____ _____

Insurance Company Name | Group ID/Policy Number | Member Number

_____ _____

Relationship to Cardholder (Self, spouse, child) | Nome of Cardholder

Care Goal

◯ Pain Relive

◯ Corrective Care

◯ Prevention

◯ I would like the doctor to select the appropriate type of care for my conditions

List any other doctor you have consulted for this condition

1. _____ 2. _____

You have received chiropractic care in the past: ◯ YES ◯ NO

Chiropractic Name: _____

Signature _____ Patient Name_____

Patient Name: _____ Date: _____

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

Since when have you had your main problem?

_____

How did your main problem appear?

○ Gradually ○ Suddenly ○ Accident/trauma ○ Do not know

Us your problem present?

○ 100% of the time ○ 75% of the time ○ 50% of the time ○ 25% of the time

○ Less than 25% of the time

Is your problem worse?

○ Better ○ Day ○ Evening ○ Night

Does your problem affect you?

○ Working ○ Sleeping ○ Your daily routing

Have you seen another health professional for your problem?

○ No ○ Chiropractor ○ Medical ○ Other

Have you had your main problem before? ○ Yes ○ No

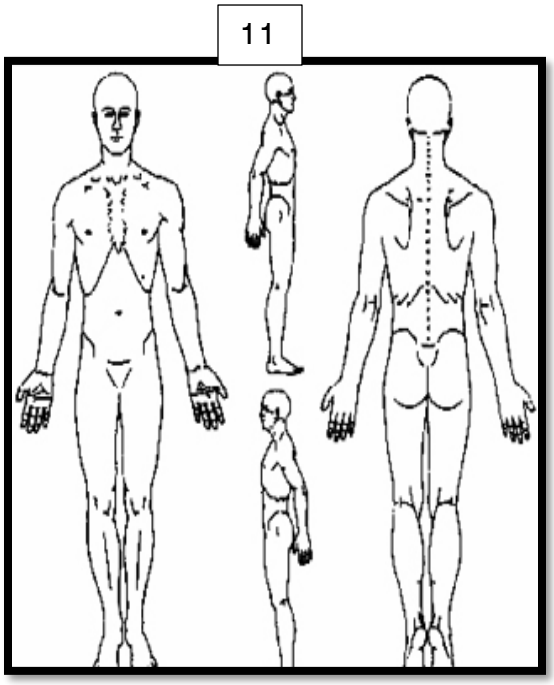
Indicates the severity of your main problem

(No problems) 0 1 2 3 4 5 6 7 8 9 10 (Extreme problem)

Indicate the level of your effort to correct it

(Not pawned) 0 1 2 3 4 5 6 7 8 9 10 (Pawned)

#11 Check the box that indicates the severity of your main problem



Pregnancy notice: To my best knowledge I am not pregnant. I understand that x-rays can be harmful to a child who is about to be born.

Last menstrual cycle: _____

Consent for the care of a minor child: I, being the parent or legal guardian of the minor child, give my permission for the evaluation, x-rays and chiropractic care.

Signature _____ Date: _____

Patient Name: _____ Date: _____

1. Father age _____. If deceased, cause_____
2. Mother age _____. If deceased, cause_____
3. Do you have brothers or sisters? ○ Yes ○ No
4. Do member of your family have: ○ cardiac problems ○ Diabetes ○ Cancer ○ Arthritis ○ Others: _____
5. Are you taking any medication currently?

○ No ○ Anti-inflammatory ○ Pains killers ○ Muscular relaxants ○ Hormones
○ Diabetes ○ "The pill" ○High blood pressure ○For the thyroid Gland
○ Others: _____

6. What is your work position? ○ Standing ○ Sitting ○ Moving
7. Do you wear? ○ A heel lift ○ Shoe orthotics
8. Do you usually sleep on your? ○ Back ○ Side ○ Stomach
9. How many hours do you sleep at night? ○ 4 hour and less ○ 5 – 6 hours ○ 7- 8 hours ○ 9 -10 hours ○ 10 – 11 hours ○12 hours and more
10. Do you consume…? If yes, how many?
    a. Tobacco/cigarettes? ○ Yes ○ No _____
    b. Alcohol? ○ Yes ○ No _____
    c. Coffee/Tea ○ Yes ○ No _____
    d. Do you take vitamins or supplements? ○ Yes ○ No _____
11. Do you exercise? ○ Yes ○ No _____

Have you had, or do you have any of the following problems?

Allergies	High blood pressure	Hearing problems
Anxiety	Hypoglycemia	Hormonal problems
Arthritis	Urinary incontinence	Psychological problems
Abdominal gas	Insomnia	Kidney problems
Low blood pressure	Irritability	Varicose vein problems
Constipation	Hereditary diseases	Nose bleeds
Convulsions	Back pain	Blood in the stools
Itching	Headaches	Blood in urine
Depression	Meningitis	Sinusitis
Diabetes	Edema (swelling)	Urinate frequently
Diarrhea	Operations / surgery	Urinate at night
Easily bruised	Loss or gain of weight	Prostate problems
Numbness	Kidney stones	Cancer
Epilepsy	Shaking	**Reserved for woman**
Skin eruptions (redness)	Foot problems	No menstruation
Dizziness / vertigo	Cardiac problems	Abdominal cramps
Loss of consciousness	Blood circulation problems	Abundant menstrual flow
Cold extremities	Respiratory problems	Painful menstruation
Fatigue	Eye problems	Vaginal loss
Fractures	Digestive problems	Menopause symptoms
Shivers	Sexual problems	Are you pregnant?

Additional comment: _____
_____
_____

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Dynamics Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health
- care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, reevaluations or other appointment related tissues. Pictures and patient stories may be used in office for bulletin boards and patient education.
Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangement will be made for you.

We do not diagnose conditions or diseases, except for vertebral subluxations. We do not offer any treatment of conditions or disease, except for vertebral subluxations. We promise no cure of any condition or disease.

Our goal is to locate, analyze and correct interference in the nervous system. The purpose of the nervous system is to control and coordinate all body function.

I, _____ have read the above statement and I fully understand it. I start my chiropractic care on this basis.

_____
Patient Name

_____ _____
Patient Signature (or legal guardian) Date