Bearor Family Chiropractic Health Profile

Name_____ Date____/____/____ Age_____ Male/Female

Address_____ City_____ State_____ Zip _____

Phone: Cell_____ Home_____

Email Address_____ Date of Birth ____/____/____

Occupation_____ Employer's Name _____ Type of Work _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages, & Gender_____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1= mild 10=unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury	Are symptoms constant or Intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? YES / NO

Chiropractor _____ Medical Doctor_____ Other_____

Who and when? _____

CIRCLE ALL CURRENT HEALTH PROBLEMS YOU HAVE

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	TMJ - RIGHT/ LEFT	NUMBNESS IN ARMS - RIGHT/ LEFT
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	HIP PAIN - RIGHT/LEFT	NUMBNESS IN HAND - RIGHT/LEFT
VERTIGO	ASTHMA	IRRITABLE BOWEL	LEG PAINS - RIGHT/LEFT	NUMBNESS IN LEGS - RIGHT/ LEFT
ULCERS	EAR INFECTIONS	LIVER DISEASE	ARM PAIN - RIGHT/LEFT	NUMBNESS IN FEET- RIGHT/LEFT
NAUSEA	CHRONIC FATIGUE	ALLERGIES	KNEE PAIN - RIGHT/LEFT	SHOULDER PAIN - RIGHT/ LEFT
NECK PAIN	LOW BACK PAIN	CHEST PAIN	SCIATICA - RIGHT/LEFT	STOMACH DISORDERS
MIGRAINE	HEART DISORDERS	FIBROMYALGIA	BLADDER PROBLEMS	GASTRIC REFLUX
ADD/ADHD	CHRONIC SINUS	ANXIETY	PAIN IN BUTTOCK	NERVOUS/NERVOUSNESS
DISC PROBLEM	EPILESPY	INFERTILITY	MENSTRUAL DISORDER	MID-BACK STIFFNESS
NECK STIFFNESS	LOW BACK STIFFNESS			

<u>CIRCLE</u> ANY CONDITION YOU HAVE NOW / HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL Surgical Operations & Years _____

_____

OTHER TRAMUAS:_____

LIST ALL Over the Counter & Prescription Medications You Are On:

_____

_____

Have you ever been in an auto accident? YES / NO When? _____

Have you had previous chiropractic care? YES / NO When was your last visit? _____ How often did you go? _____

What was the reason for your initial visit there? _____

How long where you receiving chiropractic adjustments? _____ Why did you discontinue care? _____

SOCIAL HISTORY

1. **SMOKING: ___**Cigars ___Pipe ___Cigarettes → How Often? ___Daily ___Weekends ___Occasionally ___Never

2. **EXERCISE:** → How Often? ___Daily ___Weekends ___Occasionally ___Never

3. How does your present problem affect the following? **Hobbies / Recreational Activities/ Exercises Regime**

_____

4. What Daily Activities are being restricted by your current health problems:

_____

_____

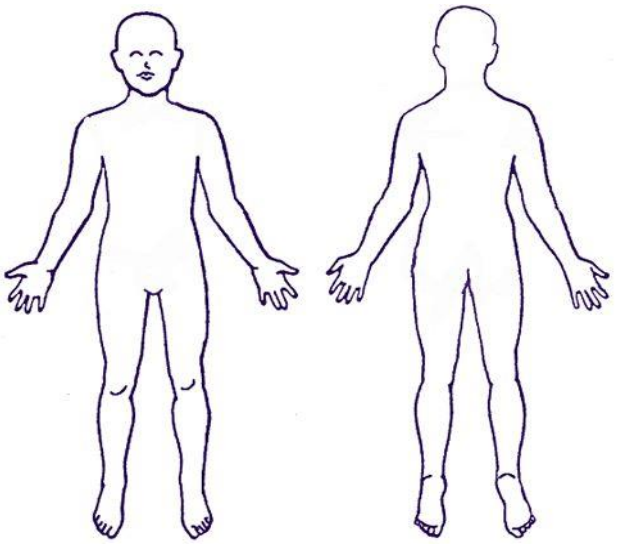
*__PLEASE MARK__ the areas on the Diagram with the following **LETTERS** to describe your symptoms:
R= Radiating **B= B**urning **D=D**ull **A=A**ching **N=N**umbness **S=S**harp/**S**tabbing **T=T**ingling

What relieves your symptoms? _____

_____

What make them feel worse? _____

_____



QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

No Pain headache neck low back **Worst Possible Pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1. What is your pain **RIGHT NOW**?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST** (How close to "0" does it get at its best)?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____ Examiner

Practice Member Information (Must be Completed Before Services Can be Rendered)

NAME: _____
First Middle Last

PHONE: Cell_____ Home _____

Work _____

Social Security Number: _____ Marital Status: _____

Date of Birth: _____

Contact in Case of Emergency: _____ Phone #: _____

Name of Primary Insurance Carrier: _____

Policy Holder Name _____ Policy Holder's Date of Birth _____

Name of Secondary Insurance Carrier: _____

Policy Holder Name _____ Policy Holder's Date of Birth _____

Release of Authorized/ Assignment of Benefits

I authorize and request payment of insurance benefits directly to R. Nathan Bearor, DC I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ Date _____

Family Health History

This form is to assist the doctor by providing past health history information for his review.

_____ _____

Please Print Your Name Here Date

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIRGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					
DIABETES					

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your X-rays in our files.

PLEASE NOTE: X-Rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Bearor Family Chiropractic do not diagnose or treat medical conditions; However, if any abnormalities are found, we will bring it to you attention so that you can seek proper medical advice.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

Print Your Name Here Date

_____ _____

Signature Your Age

FEMALE PATIENTS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time X-rays are taken at Bearor Family Chiropractic.

_____ _____

Signature Date

DO NOT WRITE BELOW THIS LINE

Lateral Cervical	A-P Cervical	A-P Thoracic
Lateral Lumbar	A-P Lumbar	Notes:

Terms of Acceptance

In order to provide 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 our office:

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 and 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 by 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 prompt referral to an appropriate provider or specialist, according to 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 office, its nature, duration, or cost, is 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 or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as assessments and physician's certifications.
4. This office provides chiropractic care in a partially open adjusting environment.
5. It is also the practice of this office to display, on a bulletin board, patients celebrating birthdays for the month, as well as displaying each new patient and the person who referred them to our office, as well as paper sign in sheets.

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 disclose 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 instances 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 at Bearor Family Chiropractic, 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.

Name of practice member is a minor/child_____

I authorized Dr. R Nathan Bearor and any and all of Bearor Family 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 Bearor Family Chiropractic.

_____ _____

Signature of Guardian Date

_____ _____

Relationship to minor/child witness signature