ADULT CONSULTATION HISTORY

Welcome to our practice! Please complete all questions and write legibly. Thank you.

Date: ______________________ Social Security #: __________________________ File #: __________

Name (printed): ____ Preferred Name: ________________

Address: ___________________________________ City: ______________ State: ___ Zip: ___________

Phone – Home: ______________________ Work: ____________________Cell: ____________________
P

E-mail: ____ Date of Birth: ________________ Age: ______

Sex: M F Occupation: ___________________________ Employer: ___________________________

Marital Status: M W D S Spouse's Name:____________________________ # of Children: _____

Primary Care Physician Name ____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

○ HEADACHE ○ NECK PAIN ○ MID-BACK PAIN

○ LOW BACK PAIN ○ OTHER

Date problem began: _______________

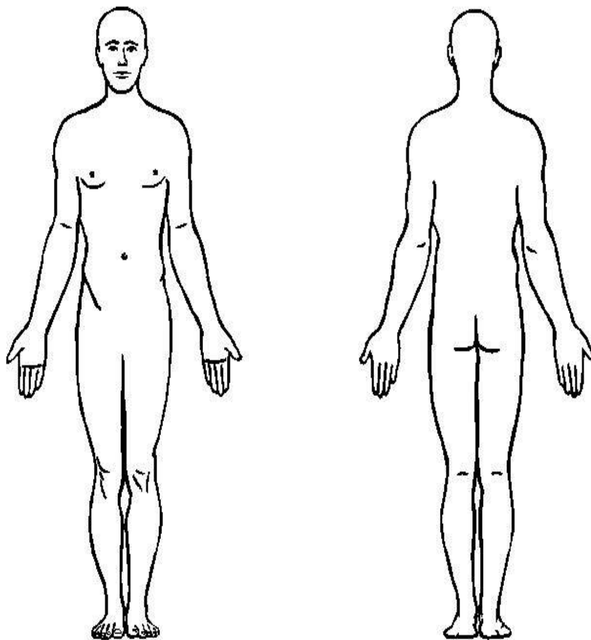
How problem began: _______________

____

____

____

MARK LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW

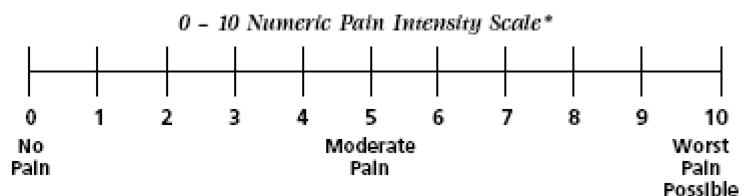


Overall health right now is:

○ EXCELLENT ○ VERY GOOD

○ GOOD ○ FAIR ○ POOR

Circle the number on the pain scale below that best describes your pain level today:



ADULT CONSULTATION HISTORY

How often are your symptoms present?
(Occasional) 0-25% ○ 26-50% ○ 51-75% ○ 76-100% (Constant) ○

Are you currently taking any drugs? If so, please list:
____

Have you had any major surgery or operations? (Please describe)
____

Any other hospitalizations besides those listed above? (Please describe)
____

Have you had any previous chiropractic care? If so, please list doctor's name and date of last visit if within the last year: ____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. 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.

____
Printed name of patient

____ ____________________
Signature of patient Date

ADULT CONSULTATION HISTORY

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- □ Pneumonia
- □ Rheumatic Fever
- □ Polio
- □ Tuberculosis
- □ Whooping Cough
- □ Measles

- □ Mumps
- □ Smallpox
- □ Chicken Pox
- □ Diabetes
- □ Cancer
- □ Heart Disease

- □ Thyroid Condition
- □ Pleurisy
- □ Arthritis
- □ Epilepsy
- □ Mental Disorders
- □ Eczema

INTAKE

- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ Illicit Drugs

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD IN THE PAST SIX MONTHS:

NERVOUS SYSTEM

- □ Numbness
- □ Paralysis
- □ Dizziness/Fainting
- □ Forgetfulness
- □ Anxiety
- □ Depression
- □ Confusion
- □ Cold/Tingling Extremities
- □ Convulsions
- □ Stress

MUSCULO-SKELETAL

- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/ Stiffness
- □ Walking Problems
- □ Difficulty Chewing/Clicking Jaw
- □ General Stiffness

EENT

- □ Vision Problems
- □ Sore Throat
- □ Earaches
- □ Hearing Difficulty
- □ Stuffed Nose

GASTROINTESTINAL

- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating After Meals
- □ Heartburn
- □ Colitis

URINARY

- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R

- □ Chest Pain
- □ Shortness of Breath
- □ Blood Pressure Problems
- □ Heart Problems/Irregularities
- □ Lung Problems/Congestion
- □ Varicose veins/Ankle swelling
- □ Stroke

GENERAL

- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Fever
- □ Headaches

MALE

- □ Sexual Dysfunction
- □ Prostate Problems

FEMALE

- □Menstrual Irregularity
- □ Menstrual Cramps
- □Vaginal Pain/Infection
- □ Breast Pain/Lumps
- □ Sexual Dysfunction

Are you pregnant?

□ Yes □No □Not sure

OTHER PROBLEMS:

- □ ________________
- □ ________________

HIPAA: Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, healthcare, and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

Right to Change: We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Janie Haun, DC, Haun Chiropractic, LLC., 2105 E. Center St. Ste. C, Kingsport, TN. 37664 (423) 765-9911.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, healthcare, and practice operations. I also acknowledge that I have received a copy of, and agree to, Haun Chiropractic's Notice of Privacy Practices.

____ ___________________________

Signature Date

TERMS OF ACCEPTANCE

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each practice member understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of symptoms or disease.

Vertebral Subluxation: a misalignment of one or more of the 26 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, ____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care for myself on this basis.

____ _________________________________

Signature Date

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and /or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute any action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and /or recovery in this state of Tennessee.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

______________________ ____
Date Patient/Insured Signature

RECORDS RELEASE

To_________________________________, I hereby authorize you to release to _________________________ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from ____________________ to _____________________.

________________ ___________________________________
Date Patient/Insured Signature

________________ ___________________________________
Date Staff Signature

PERMISSION TO CONTACT REGARDING PATIENT CORRESPONDENCE

Please check the following that apply:

__ I give Haun Chiropractic permission to contact me for the purpose of appointment reminders.

__ Text messages (please provide cell phone **carrier**______________________)

__ Email (please provide email address__________________________)

__ I give Haun Chiropractic permission to contact me for the purpose of patient communication, education, and general office information.

__ Email (please provide email address__________________________)

Haun Chiropractic will only use your contact information for the above stated reasons. We will never distribute or sell your contact information to anyone outside of Haun Chiropractic.