TORCH CHIROPRACTIC Family Wellness Center

Today's Date: _____

Full Legal Name (printed):_____Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Home Phone: (___)-____-_____ Business: (___)-____-_____ (Please circle your preferred contact method)

E-mail Address: _____Cell phone: (___)-____-_____carrier: _____

Date of Birth: ___/___/____ Age: ____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Current Height: _____ Current Weight: _____

Name of spouse or significant other: _____Occupation:_____

Number of children: ___ Names and ages of children: _____

Who may we call in case of emergency: _____Phone: _____Relationship: _____

Who may we thank for referring you to our office: _____

INSURANCE

Primary Insurance Company: _____ Policy Number: _____

Insured's Name: _____ Insured's Birth date: _____

FOR WOMEN

Are you pregnant? □Y □N Date of last menstrual period: _____ If pregnant, Due Date: _____

Name of OBGYN or Midwife: _____

Where will you be birthing your baby? □Hospital □Home □Birthing Center □Other_____

CARE HISTORY

The primary system in the body which coordinates health is the CENTRAL NERVOUS SYSTEM. The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of the injury to the SPINE & NERVE SYSTEM.

Have you ever received Chiropractic care? □ Y □ N Name of D.C._____

How long under care? #____days #_____weeks #_____month #____years

Date of last visit: ___/___/___ Why did you stop?_____

Have you/do you regularly consult any of the following providers? (Check all that apply)
□ Medical Physician □ Naturopath □ Acupuncturist □ Homeopath □ Massage Therapist

□ Psychotherapist □ Energy Healer □ Dentist

Reason(s) why you're seeing them? _____

HEALTH HISTORY

List any **accidents, falls, or traumas** that you have had and the approximate date.
Date: _____ Describe: _____
Date: _____ Describe: _____
Date: _____ Describe: _____

List any **Illnesses** that you have had and the approximate date.
Date: _____ Describe: _____
Date: _____ Describe: _____

List **surgeries and hospitalizations** that you have had and the approximate date.
Date: _____ Describe: _____
Date: _____ Describe: _____

Check the following conditions you have had.

	Alcoholism		Emphysema		Heart Disease		Pneumonia
	Appendicitis		Epilepsy		Hepatitis A B C		Polio
	Arteriosclerosis		Fibromyalgia		HIV		Stroke
	Diabetes		Goiter		Hypoglycemia		Tuberculosis
	Diphtheria		Gout		Multiple Sclerosis		Other

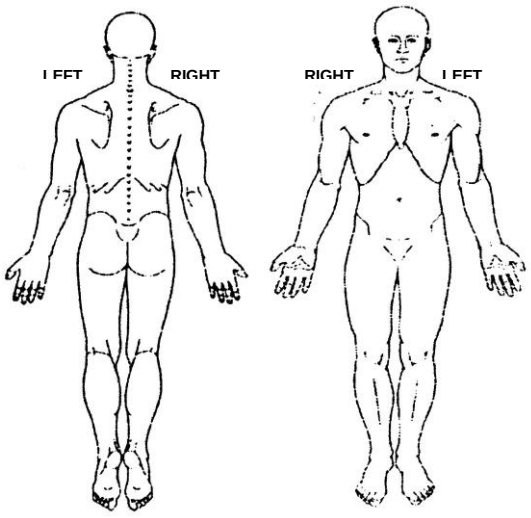
Check any of the following symptoms which you have now or have had in the past.

Now	Past	General	Now	Past	Gastro-Intestinal	Now	Past	Cardiovascular
		Severe or frequent headaches			Belching/Gas			High Blood Pressure
		Anemia			Ulcer/Colitis			Low Blood Pressure
		Cancer			Frequent Constipation			Cold Hands or Feet
		Depression			Frequent Diarrhea			Chest Pain
		Anxiety/Nervousness			Liver Trouble			Heart Surgery/Pacemaker
		Fatigue or Weakness			Gall Bladder Trouble			Rapid/Slow Beating Heart
		Loss of sleep			Acid Reflux/Difficult Digestion			Swelling Ankles
		Difficulty concentrating			**Skin/Bone**			Varicose Veins
		Mood swings or irritability			Bruise Easily			**Respiratory**
		Unexpected weight loss or gain			Hives or Allergy			Asthma
		Loss of Balance			Bone Fracture			Chest Pain
		Seizures			Dislocated Joints			Chronic Cough
		Dizziness/ Vertigo			Osteopenia / Osteoporosis			Difficulty Breathing
		Tremors			Arthritis			Wheezing
		Thyroid Disease			Bursitis			**Genito-Urinary**
		Pain/ Numbness in			**E.E.N.T.**			Bed Wetting
		Neck			Allergies			Blood/Pus in Urine
		Upper Back			Frequent Colds			Incontinence
		Shoulders			Hearing Trouble			Kidney or Bladder Trouble
		Elbows			Earache/ Ear Infections			Urinary Pain or Frequency
		Hands			Ringing or Buzzing in Ears			Prostrate Trouble
		Lower Back			Vision Trouble			Menstrual Problems or Pain
		Hips			Sinus Trouble			Erectile Dysfunction
		Legs			Loss of Smell or Taste			Fertility Problems
		Knees			Difficulty Swallowing			Hot Flashes (Menopausal Symptoms)
		Feet			Difficulty Speaking			Miscarriage
		Sciatica			Tonsillitis			

Name: Date:

Please indicate on the diagram below all the areas where you experience discomfort or pain:

Describe your discomfort (check all that apply)	**Describe type of Pain** (check all that apply)
□Numbness	□Sharp
□Tingling	□Dull
□Aches	□Throbbing
□Swelling	□Constant
□Stiffness	□Intermittent
□Cramping	□Shooting
□Burning	□Stabbing



Describe problem area (if any)

When did the problem begin? (please specify a date)_____

How did the problem begin? _____

_____

Does the pain travel? _____

Please rate the intensity of the pain at its worst. (none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

Please rate the intensity on an average day. (none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

How often do you experience the pain? __Constant ___ Daily ___ #days/wk ___ #days/months
How long does an episode last? ___Constant ___ Minutes ___ Hours ___ Days

What makes the pain better? _____
What makes the pain worse? _____

Have you had pain like this before this episode? _____

Are you seeing another health care provider regarding this issue? □Yes □No
Health Care Provider's Name:_____

Has the discomfort interfered with your work or other activities? □Yes □No
If yes, please list:_____

Is this pain due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing **damage to the nerve system.** The result is a condition called **Vertebral Subluxation.** The Chiropractic Exam/evaluation is specifically designed to **detect Vertebral Subluxations** in all phases of their progression.

EMOTIONAL STRESS

Childhood Trauma	Y N	Loss of loved one	Y N	Abuse	Y N
Work or School	Y N	Divorce/separation	Y N	Financial	Y N
Lifestyle change	Y N	Parents divorce	Y N	Illness	Y N

Do you think you might be under any stress? _____

Do you have any difficulties sleeping or falling asleep? _____

Do you have an active support system? _____

CHEMICAL STRESS

Were you **vaccinated?** ❑ Y ❑ N I

f yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following biochemical stresses (past or present)?

❑ Toxic chemicals ❑ Second Hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list: _____

Do you have **allergies** to any foods? ❑ Y ❑ N

If yes, please list: _____

Do you **consume** any of the following presently? If so, how much do you consume each day/week?

Coffee/Caffeine	
Alcohol	
Tobacco	
Over The Counter Drugs	
Prescription Drugs	

Please list all medications (prescribed and over the counter):_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**?	❑ Good	❑ Fair	❑ Poor
How do you grade your **emotional/mental health**?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall **"quality of life"**?	❑ Good	❑ Fair	❑ Poor

Do you **exercise** regularly? If so, how often? _____

Do you take **supplements**? If yes, please list: _____

How many glasses of **water** do you drink each day? _____

Do you follow a **special dietary regime**? If yes, what? _____

I would like to have the following benefits from *Chiropractic Care*: (Check all that apply)

❑ Relief of a symptom or problem
❑ Relief and prevention of a symptom or problem
❑ Healthier spine and nerve system
❑ Optimal health on all levels

TORCH
CHIROPRACTIC
Family Wellness Center

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening in the body's innate ability to express its maximum healthy potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, 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. THE ONLY OBJECTIVE of Torch Chiropractic Family Wellness Center is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I wish to rely on the doctor's judgment during the course of the procedure, but do not expect the doctor to be able to anticipate and explain all risks. I understand and am informed that there is a small risk to treatment, including but not limited to, fractures, disc injuries, dislocations, and sprains.

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 complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____

Patient's or Guardian's Signature *Date*

TORCH
CHIROPRACTIC
Family Wellness Center

Insurance Consent

Your insurance company will only pay for services that they determine are medically necessary. As a Torch Chiropractic Family Wellness Center member, you must understand that some or all services provided for your care might not be covered by your contract benefits. You, as a wellness center member, are liable for all charges that your plan does not cover including your deductible, co-insurance, co-payment and other charges incurred by you.

I have been notified by my chiropractor that my insurance may not cover all the service provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment.

Signed,

_____

Patient/Guardian *Date*

Terms of Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Trevor Darnell, DC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Torch Chiropractic Family Wellness Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____

Patient's or Guardian's Signature *Date*

_____

Torch Chiropractic Representative Date

Patient Health Information Consent Form

Torch Chiropractic Family Wellness Center wants you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and security, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient *Signature* *Date*