Healthlink Family Chiropractic Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

Section 1: Patient Information

Appt. Date: _____ **Referred *By:*** _____

Name (first, middle, last):_____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ___/__/_____ Age: _____

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

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employer: _____ Occupation: _____ Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children: _____

Emergency Contact: _____ Relationship_____ Phone # (____) _____

Section 2: History of Complaint

Primary Complaint(s): _____

Secondary Complaint(s): _____

Are your complaints due to an Accident? ☐ YES ☐ NO If yes, what type? ☐Work ☐Auto ☐ Personal

Date of Accident_____ If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No

Who was it reported To? _____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

_____

List any medications you currently take. (Prescription and non-prescription)_____

_____

_____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ❑ No ❑ Yes

If yes whom & what condition(s): _____

_____

Section 4: Chiropractic History

Have you ever seen a Chiropractor before? ☐ Yes ☐ No When _____/_____/_____

For what reason were you seen?_____ Were you helped? ☐ YES ☐ NO

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 5: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end** **10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐Lt ☐Rt

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries:_____ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: **1-1-2008** ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice & bruised Left Elbow**

Date:___/__ /_____ Type of Injury:_____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

D. Repetitive Injuries (Please list **all** repetitive injuries you've had in the past.)

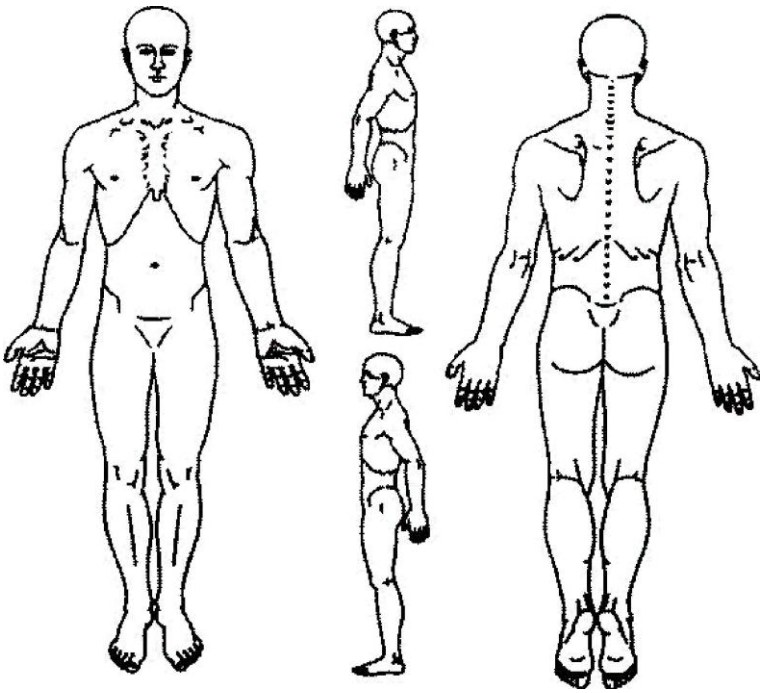
Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 6: Present and Past Conditions

Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R & L*** .

P = **P**ast Health Issue **C** = **C**urrent Health Issue **N** = **N**ever had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities	Location	tory	Other Conditions	Male
___ Hip ☐ Pain ☐ Stiff	☐ R ☐ L	___ Asthma	___ Headaches / Migraines	___ Impotence
___ Knee ☐ Pain ☐ Stiff	☐ R ☐ L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Foot ☐ Pain ☐ Stiff	☐ R ☐ L	___ Difficulty Breathing	___ Excessive Sweating	**Female**
___ Shoulder ☐ Pain ☐ Stiff	☐ R ☐ L	___ Lung Problems	___ Cancer & Type: _____	___ Menopausal Problem
___ Elbow ☐ Pain ☐ Stiff	☐ R ☐ L	___ COPD	___ Emotional / Mental Disorders	___ Menstrual Cycle Problems
		Digestion	___ Learning Disability	
___ Wrist ☐ Pain ☐ Stiff	☐ R ☐ L	___ Heartburn	___ Nervous / Irritable	
___ Jaw Pain ☐ Click ☐ Pop	☐ R ☐ L	___ Digestion Problems	___ Loss of Memory	**Social History**
___ Swollen or Painful Joints		___ Gallbladder Problems	___ Dizziness / Loss of Balance	____ Smoking How much _____ How Often _____
Spine		___ Colon Trouble	___ Arthritis	
___ Head / Shoulders Feel Heavy / Tired		___ Diarrhea / Constipation	___ Epilepsy / Convulsions	
___ Neck ☐ Pain ☐ Stiff	☐ R ☐ L	___ Hemorrhoids	___ Knocked Unconscious	____ Alcoholic Beverage Consumption Occurs_____
___ Upper Back ☐ Pain ☐ Stiff	☐ R ☐ L	**Immune System**	___ Frequent Ear Infections	
___ Mid Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Skin Problems	___ Ringing in Ear R / L	
___ Low Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Sinus Problems/ Allergies	___ Hearing Loss R / L	____Recreational Drugs What Used_____ How Often_____
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:_____		___ Frequent Colds / Flu	___ Trouble Concentrating	
		___ Anemia	___ AIDS / HIV	
Other:_____		___ Other: _____	___ Fracture / Dislocation of Bones: _____	____Exercise Type_____ How Often_____
		Organ Problems or Dysfunction	___Other: _____	
Numbness / Tingling or Pain In:		___ Diabetes	**Urinary Tract**	
___ Arm	☐ R ☐ L	___ Liver Trouble	___ Kidney Trouble	
___ Hand /Fingers	☐ R ☐ L	___ Hepatitis	___ Frequent Urination	
___ Legs	☐ R ☐ L	___ High/Low Blood Pressure	___ Bedwetting	
___ Foot / Toes	☐ R ☐ L	___ Heart	___ Other:_____	

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 7: Functional Assessment: Check any activities of life that your current conditions are affecting:

- ☐ Sitting
- ☐ Sit to Stand
- ☐ Standing
- ☐ Walking
- ☐ Driving
- ☐ Sleep/Rolling
- ☐ Reading
- ☐ Computer Use
- ☐ Yard work/Gardening
- ☐ Running
- ☐ Climbing
- ☐ Pushing/Pulling
- ☐ Dressing/Shaving
- ☐ Dishes/Laundry
- ☐ Bending
- ☐ Lifting
- ☐ Exercising/Sports

Doctors Notes: _____

_____

Section 8: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: ***when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain)*** **.**

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident_____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

List any past hospitalizations and/or surgeries:

Surgeries: _____

List Hospitalizations Other Than Surgeries: _____

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Revised 1110812

CONSENT FOR A MINOR/CHILD

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW WRITTEN CONSENT FOR A CHILD. NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD

_____

I AUTHORIZE DR. MARIO PERAZZA AND ANY AND ALL HEALTHLINK 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 HEALTHLINK FAMILY CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

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(s) OF HEALTHLINK FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR 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 HEALTHLINK FAMILY CHIROPRACTIC.

_____ _____

SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____

_____

_____

_____

_____

_____

_____

Initials: _____

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

NAME: _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$100.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$70.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $35-$45 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Mario Perazza, D.C. 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**_____

Terms of Acceptance

In order to provide for 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 this clinic:

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 of this 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 a prompt referral to an appropriate provider or specialist, according to the 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 though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in 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 and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

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 INCLUDES: 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 INSTANCE 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 IN THIS CHIROPRACTIC OFFICE, 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.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**