

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Cell Phone: () _____ Alternate Phone: () _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day Cell Provider: _____

Email: _____ *(For updates on office hours, events, etc.)*

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

of Children: _____

Children's Names & Ages: _____

Who can we thank for referring you or how did you hear about Peak Potential Family Chiropractic?

REASON FOR SEEKING CARE

What is your reason for seeking care at Peak Potential? _____

When did this begin? _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your life? (List all that apply)

Have you seen any other providers for this condition? (List all that apply)

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

Goals For Care:

1. _____

2. _____

3. _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

HEALTH CONCERNS

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Brain Fog | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Autoimmune Issues | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stiffness/Flexibility |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinus Congestion/Allergies |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Food Sensitivities/Allergies |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Menstrual Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Breathing Difficulties |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Hand Numbness/Tingling |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Feet Numbness/Tingling |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Other _____ |

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other | |
-

VITAMINS / SUPPLEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

STRESS QUESTIONNAIRE

Physical Stress

- History of Accidents/Injuries Limited Exercise Sit at Work

Chemical Stress

- Fast Food/Highly Processed Food Medications (Prescription or OTC) Alcohol Tobacco

Emotional Stress

- Work School Health Finances Family Busy Schedule Past Trauma

QUALITY OF LIFE

Please rate your GENERAL stress level, 0-10 _____ At Work _____ At Home _____

How do you think you handle your stress? _____

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional / mental health? Excellent Good Fair Poor

How do you rate your overall quality of life? Excellent Good Fair Poor

Do you exercise regularly? If yes, how often? _____

Do you follow a special dietary regimen? _____

Your Expectations for Chiropractic Care (check all that apply):

- Resolution of a symptom or a problem
 Resolution & Prevention of a symptom or a problem
 Healthier spine & Nervous system
 Optimal health on all levels
 Other: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Electronic Signature: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Peak Potential Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to Peak Potential Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case and by any insurance company obligated to make payment to me or Peak Potential Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Peak Potential Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Peak Potential Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Peak Potential to treat my condition as deemed appropriate. At Peak Potential Family Chiropractic we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Peak Potential Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____