Health History

Patient Information

Name: _____ Today's Date: _____/_____/_____

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

Email: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( )_____ Ext: _____ Circle: Male / Female Birthdate: _____/_____/_____

Occupation: _____ Marital Status: _____

Number of Children and Ages: _____ Have you received previous chiropractic care? Yes / No

Would you like us to submit your claims to insurance? Yes / No Insurance carrier: _____

Emergency Contact: _____ Phone Number: _____

Referral

Our clinic is primarily referral based. We would like to know who we can *thank* for sending you to us! Please let us know where you heard about our clinic, or who referred you: _____

Primary Complaint

Main reason(s) for seeking care: _____

Patient History

Did or do you smoke? Yes / No Did or do you drink alcohol? Yes / No Do you primarily eat whole foods? Yes / No

Please list any accidents, slips, falls, sports injuries, etc.: _____

_____

Please list any surgeries including dates: _____

_____

Please list any prescription or over the counter medications, including what you take them for: _____

_____

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Symptoms

If you suffer from any of the following, please check. Note L for left or R for right sided problems.

- □ Headaches
- □ Migraines
- □ Neck Pain or Stiffness
- □ Shoulder/Arm/Hand Pain or Stiffness
- □ Arm/Hand Numbness or Tingling
- □ Cold Hands
- □ Mid Back Pain or Stiffness
- □ Abdominal Pain
- □ Low Back Pain or Stiffness
- □ Pelvic/Hip Pain or Stiffness
- □ Leg/Foot Pain or Stiffness
- □ Leg/Foot Numbness or Tingling
- □ Cold Feet
- □ Arthritis
- □ Disc Problems
- □ Dizziness/Vertigo
- □ Loss of Balance
- □ Decreased Concentration
- □ Loss of Sight
- □ Loss of Hearing
- □ Loss of Taste
- □ Loss of Smell
- □ Light Bothers Eyes
- □ Weakness
- □ Fatigue
- □ Difficulty Sleeping
- □ Recent Weight Loss
- □ Recent Weight Gain
- □ Swelling
- □ Loss of Consciousness
- □ Seizure
- □ Acid Reflux
- □ Diarrhea
- □ Constipation
- □ Mental Stress
- □ Frequent Colds/Flus
- □ Ear Infections
- □ Sore Throat
- □ Sinus Problems
- □ Nose Bleeds
- □ Cough
- □ Fever
- □ Chest Pains
- □ Anxiety
- □ Depression
- □ Allergies
- □ Asthma
- □ Heart Problems
- □ Diabetes
- □ Hypoglycemia
- □ Urinary Problems
- □ Osteoporosis
- □ Cancer

Please note any other conditions not listed: _____

_____

Patient Signature: _____ Date: _____/_____/_____

**** For Minors (Under 18 years of age):** I am the legal guardian of _____, and hereby authorize chiropractic care and clinical nutrition as deemed necessary by Two Roads Wellness Center.

Relationship _____ Signature: _____ Date: ____/____/_____

**** For Women:** Is there a possibility that you could be pregnant? Yes / No

Health History

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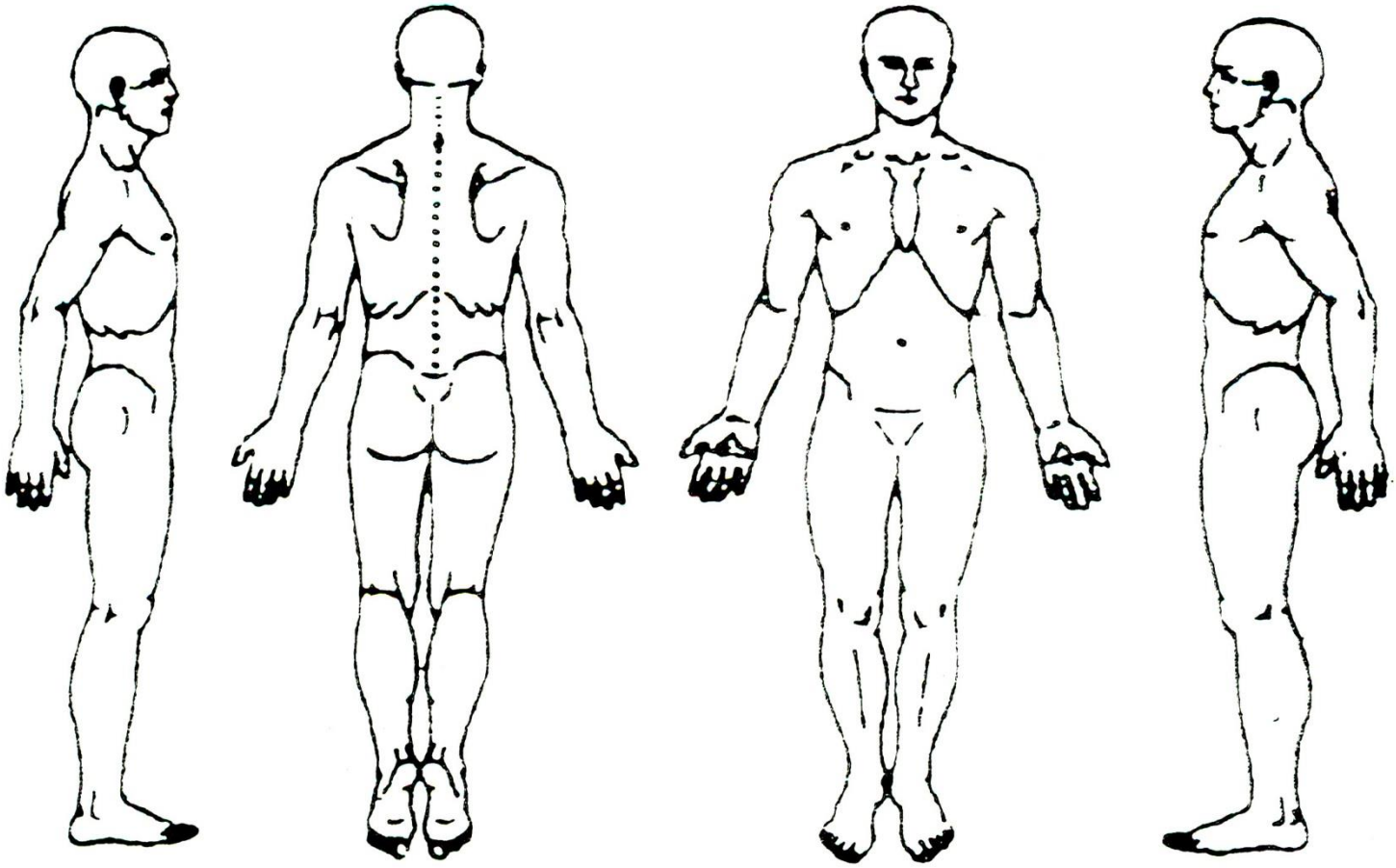
Please mark recent problem areas on the illustrations below and answer the following questions:



What is the most recent date you have experienced your symptoms? _____

Can you think of anything that caused the problem? _____

Have you experienced anything like this before? _____

Is there a family history of similar issues? _____

Is there anything that makes you feel better? _____

Is there anything that makes you feel worse? _____

Can you describe how it feels? (Achy, sharp, tingling, numb, etc.) _____

Do the symptoms stay local to the area or do they travel someplace else? _____

On a 0-10 scale with 0 being no symptoms and 10 being unbearable, where would you rate yourself today? _____

Are the symptoms constant or do they come and go?_____

Is there any time of the day or any activity during which you notice the symptoms more? _____

At our office, our goal is to render the highest quality chiropractic care & clinical nutrition at the lowest possible fee. If you are not using health insurance at our office, you may skip ahead & read under the outlined box & sign below. If you are using insurance, please read this entire page thoroughly & sign below.

Insurance policies vary greatly in what services they will pay for. Some policies are more complete than others, and cover more services. Our office staff will attempt to contact your insurance company before or during your first visit, to find out what services are covered by your particular contract. We do this in a sincere attempt to inform you of your expected health care costs. We will be glad to prepare, and send your insurance claims for you. When we send in your claims we will "accept assignment". This means that your insurance company will pay their portion of your claim directly to our office.

You may still be financially responsible for the following:

- Deductible:
  An initial amount in health care expenses that you must pay each year before your insurance begins payment. You will be charged for each visit until your deductible is satisfied. The deductible amount renews each year, typically on a calendar year cycle.
- Co-payment/Co-insurance:
  A percentage, or set dollar amount of all charges after any deductible requirements. Payment of your ESTIMATED co-payment or co-insurance is expected at the time of service.
- Uncovered Services:
  You are responsible for payment of any services not covered by your insurance company for any reason. If you have another insurance, it may cover services that your first insurance policy does not. Please inform our staff if you have more than one insurance policy.

Insurance is a contract between you, your employer and the insurance company. Our office is not a party to that contract. Two Roads Wellness Center cannot be held responsible for any incorrect information provided to us by your insurance company. Your insurance company states that benefits quoted are NOT a guarantee!

Responsibility for payment rests ultimately with you

Payment for services is due at the time services are rendered. We accept cash, check, MasterCard, Visa, Discover & American Express. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. We will be glad to address any questions about the above information or any concerns regarding your quoted insurance benefits, please don't hesitate to ask us.

By my signature below I acknowledge that I have read the above information and agree that I am responsible for all costs incurred at Two Roads Wellness Center.

_____ _____

Patient name (print) Signature

_____

Date

**Representative of minor? Y / N Relationship to minor: _____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward 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 force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health:

A state of optimal physical, mental and social well-being, not merely the absence of disease or 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 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 a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those 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. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

To initiate care at our facility, there are two required visits you will be scheduled for. If you cannot attend either of these two visits, the negative impact on your care will be profound, and we cannot in good conscious initiate your care. These required visits are:

1. Initial Consultation and Examination: This visit will consist of a health history, chiropractic examination, nutritional evaluation, and x-rays if needed. (This is probably the visit you are present for now) Total time for this appointment will be about 60 minutes.

2. Report of Findings: This visit will consist of a detailed report of findings with recommendations for your care. Also included is information on chiropractic health and wellness. Recommendations on what to do between visits and a detailed explanation of your care plan. If X-rays were taken, they will also be reviewed at this time. We recommend that spouses and adult family members attend this visit with the patient. Children should not attend this visit as the material may be too advanced and children will find it difficult to stay attentive without becoming a distraction for that amount of time. Due to the time required, there are only certain times this visit is given. Check with our receptionist for available times. Total time for this appointment will be about 30 minutes.

I have read and fully understand the above statements and agree to all terms. All questions pertaining to my care in this office have been answered to my complete satisfaction. I wish to initiate care and agree to follow the office policies at Two Roads Wellness Center.

_____ _____

Patient Name (Print) Signature

_____

Date

**Representative of Minor? Y / N Relationship to minor: _____

HEALTH INFORMATION PROTECTION PORTABILITY ACT (HIPPA)

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Two Roads Wellness Center, we may use or disclose personal and health information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis or care.
- Your health care records as well as your billing records may be disclosed to another party if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, email, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions on your use of your protected health information for care, payment, or operations purposes. Such requests are not automatic and require the agreement of this office. If you are not home to receive an appointment reminder or other information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations. We are permitted and may be required to use or disclose information without your authorization in these following circumstances:

- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide you care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by persons to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also inform you regarding your health care or about the state of your account. If you receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preference. We are required by state and federal law to maintain the privacy of your patient file and the health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are also required to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy practices or any aspect of our privacy activities you should direct your complaint to: Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and this office or our staff, in any manner whatsoever, will not disadvantage you.

This notice is effective as of 05/01/2015 and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

Your signature acknowledges that you accept these policies and have been offered a copy of this notice.

_____ _____

Patient Name (Print) Signature

_____

Date

**Representative of Minor? Y / N Relationship to minor: _____