elevate FAMILY CHIROPRACTIC

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PMID:

DATE:

Personal Information

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

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

Home #: ( ) _____-_____ Mobile #: ( ) _____-_____ Cell Carrier: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: ❑ M ❑ F

Occupation: _____ Employer: _____

Work #: ( ) _____-_____ E-mail: _____

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

# of Children: _____ Names, Ages & Gender: _____

_____ Pregnant? Yes___ No___ Due Date_____

Whom may we thank for referring you? _____

Major Health Concerns

Health Concerns: (List according to severity)	**Rate of Severity** 1 = Mild 10 = Unbearable	**When did this episode start?**	**Did you have this condition before & when?**	**Did the problem begin with an injury?**	**Constant or intermittent?**
1.					
2.					
3.					
4.					

Have these symptoms effected: ❑ work ❑ family life ❑ exercise ❑ sleep ❑ other:_____

What are your health goals? 1)_____ 2)_____

Have you ever seen other doctors for these conditions?

Chiropractor? ❑Yes ❑No Medical Doctor? ❑Yes ❑No Other? ❑ Yes ❑ No

Who and When? _____

Since your problem started, is it: ❑ About the same ❑ Getting better ❑ Getting worse

What makes it worse? _____ What makes it better? _____

List all surgical operations:

1. Type: _____ Date: _____
2. Type: _____ Date: _____
3. Type: _____ Date: _____

List ALL over the counter & prescription medications you are on: _____

- ☐ Dizziness
- ☐ Headaches
- ☐ Vertigo
- ☐ Ear Infections
- ☐ Grating of Neck
- ☐ TMJ
- ☐ Neck Pain
- ☐ Migraines
- ☐ Stiffness in Neck
- ☐ Chronic Sinus
- ☐ Throat Issues
- ☐ Thyroid Issues
- ☐ Asthma
- ☐ Ulcers
- ☐ Chest Pains
- ☐ Arm Numbness
- ☐ Arm Pain
- ☐ Hand Numbness
- ☐ Shoulder Pain
- ☐ Heart Disorders
- ☐ Mid Back Pain
- ☐ Stomach Disorders
- ☐ Nausea
- ☐ Reflux
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Irritable Bladder
- ☐ Sciatica
- ☐ Leg Numbness
- ☐ Feet Numbness
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Leg Pains
- ☐ Knee Pain
- ☐ Liver Disease
- ☐ Menstrual Issues
- ☐ Chronic Fatigue
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ ADD / ADHD
- ☐ Gerd
- ☐ Anxiety
- ☐ Nervousness
- ☐ Epilepsy
- ☐ Disc Problems
- ☐ Infertility
- ☐ Allergies: _____
  _____
- ☐ Other: _____
  _____
  _____
  _____

Check any conditions you have currently or in the past.

☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Spinal Surgery ☐ Seizures ☐ Spinal Fracture ☐ Scoliosis ☐ Diabetes

Accident History

List any accidents and/or injuries: (auto, work related or other - especially those related to your present condition)

1. Type: _____ Date: _____ Hospitalized: ☐ Yes ☐ No
2. Type: _____ Date: _____ Hospitalized: ☐ Yes ☐ No
3. Type: _____ Date: _____ Hospitalized: ☐ Yes ☐ No

Have you had previous chiropractic care? ☐ Yes ☐ No

If you have, doctor & date: _____

Have you ever been knocked unconscious? ☐ Yes ☐ No Fractured a bone? Yes ☐ No ☐

If yes, please describe: _____

Other Trauma: _____

Habits

- ☐ Smoking Packs/Day: ____
- ☐ Drinking Alcohol: _____
- ☐ Caffeine Cups/Day: ____

Exercise

- ☐ None
- ☐ Light Activity
- ☐ Moderate Activity
- ☐ Active
- ☐ Very Active
- ☐ Elite Athlete

Family History

	Diabetes	Heart	Kidney	Cancer	Other
Mother	☐	☐	☐	☐	☐ ____
Father	☐	☐	☐	☐	☐ ____
Brother, # of___	☐	☐	☐	☐	☐ ____
Sister, # of___	☐	☐	☐	☐	☐ ____

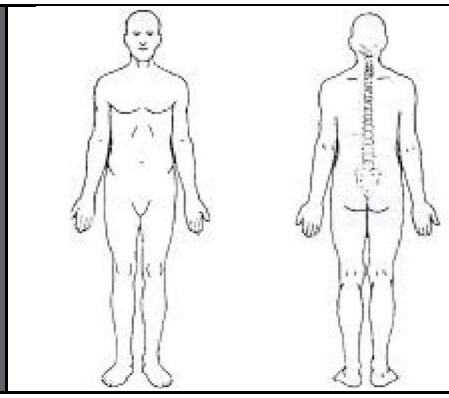
Please mark the intensity of your pain.

1 - No Pain, 10 - Severe Pain

1. _____
   1 2 3 4 5 6 7 8 9 10
2. _____
   1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings to the right using the codes listed.

N-Numbness
T-Tingling
A-Aching
R-Radiating
B-Burning
D-Dull
S-Sharp/ Stabbing



To better serve you in our office, please check any of the conditions below that you or your family have or have had in the past:

	Yourself	Spouse	Children	Father	Mother
Acid Reflux					
ADHD					
Allergies					
Anxiety					
Arthritis					
Asthma					
Autoimmune problems					
Bed wetting					
Cancer					
Constipation					
Depression					
Diabetes					
Dizziness					
Ear Infections					
Eczema					
Fatigue					
Flu					
Headaches					
Heart problems					
Immune problems					
Indigestion					
Infertility					
Kidney problems					
Liver problems					
Menstrual problems					
Migraines					
Nausea					
Numbness					
Sciatica					
Scoliosis					
Seizures					
Sinus problems					
Stiffness					

Patient Name _____ Date _____

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

No Pain _____ **Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

---

1 – What is your pain RIGHT NOW?

No Pain _____ **Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain _____ **Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ **Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ **Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

Examiner

Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Written Consent for a Child

If this health profile is for a minor/child, please fill out and sign below.

Name of practice member who is a minor/child: _____

I authorize Dr. Naeema Olatunji and any and all Elevate Family Chiropractic staff to perform diagnostic procedures, radiographic evaluation, 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 Elevate Family Chiropractic.

_____ _____

Date Guardian Signature

_____ _____

Witness Signature (Office Staff) 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.

At your request, we will provide you with a copy of your x-rays in our files.

The fee for copying your x-rays on a disc is $20.00. This fee must be paid in advance.

Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. **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 doctors of Elevate 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.

_____ _____

Date Print Your Name Here

_____ _____

Your Age Signature

Female patients only: *please read carefully and check the box, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

Date Signature

Practice Member Information

(This page must be completed before services can be rendered.)

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

Home #: ( ) _____-_____ Mobile #: ( ) _____-_____ Work #: ( ) _____-_____

Social Security #: _____ Marital Status: _____ Birth Date: _____

In case of emergency, contact: _____ Phone #: ( ) _____-_____

Name of primary insurance carrier: _____

Name of insured: _____ Insured date of birth: _____

Insured Social Security #: _____

Do you have a HSA/FSA? (Health/Flexible Savings Account) Yes ❑ No ❑

Name of secondary insurance carrier: _____

Name of insured: _____ Insured date of birth: _____

Insured Social Security #: _____

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Naeema Olatunji, 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.

_____ _____

Signature Date

Terms of Acceptance

In order to provide 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 questions 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 types 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 through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health 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 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 physician 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 secondarily to chiropractic care include: 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

Name

_____ _____

Signature Date

If practice member is a minor/child, parent or guardian must sign below

_____ _____

Parent/Guardian's Name Parent/Guardian Signature

_____ _____ _____

Relationship to minor/child Date Witness Initials