

Personal Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobile #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Carrier: \_\_\_\_\_

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 \_\_\_\_\_

How many weeks? \_\_\_\_\_ 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: \_\_\_\_\_

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

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		Exercise	Family History				
<input type="checkbox"/> Smoking	Packs/Day: _____	<input type="checkbox"/> None	Diabetes	Heart	Kidney	Cancer	Other
<input type="checkbox"/> Drinking	Alcohol: _____	<input type="checkbox"/> Light Activity	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Caffeine	Cups/Day: _____	<input type="checkbox"/> Moderate Activity	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
		<input type="checkbox"/> Active	Brother, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
		<input type="checkbox"/> Very Active	Sister, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
		<input type="checkbox"/> Elite Athlete					

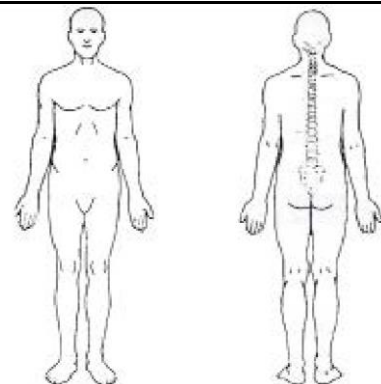
Please mark the intensity of your pain.

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 \_\_\_\_\_

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 \$15.00. 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

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.

**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

For valuable consideration, I hereby irrevocably consent to an authorize the use and reproduction by Elevate Family Chiropractic, or anyone authorized by Elevate Family Chiropractic, of any and all photographs/ videos which have been or will be taken of me, for the purposed of promotional, TV and / or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Elevate Family Chiropractic, solely and completely.

\_\_\_\_\_  
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, accept 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