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chiropractic

Last Name:

Date: ____________________ Social Security #____

Name: ____
Last First M.I

Address____

E-mail (please provide for communication purposes) ____

Cell Phone:________________________________ Home Phone: ______________________________

Sex: ______Male ______ Female Age:__________ Birthdate:_________________

____Single ___Married ____Separated ____Widowed ____Divorced ____Minor

Preferred method of communication: (Check one) Email___ Text____ + Carrier Name ___________ Phone ________

How did you find out about our clinic? ____

Patient Employer/School ____

Address:____

Phone: ____ Occupation:_______________________________________

Spouse's Name:______________________________ SS#______ - ______ - _________ Phone:__________________

Birthdate:_________________ Spouse's Employer: ____

Emergency Contact:__________________________________ Relationship:__________________ Phone_____________

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident ___________
Type of Accident: Auto ____ Work ____ Home____ Other ____

Are you currently pursuing a Worker's Compensation Board Claim? Yes_____ No_____
Are you currently **pursuing a Disability Claim?** Yes_____ No_____

***INSURANCE INFORMATION (for accident related claims only)*:**
Who is responsible for this account? ____________________ Relationship to patient:____________________________

Insurance Co:____ ID#____

Subscriber Name ____ Birthdate:_________________________________

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to Dr. Julie Paul, DC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative Date

____
Please print name of above signature Relationship to Patient

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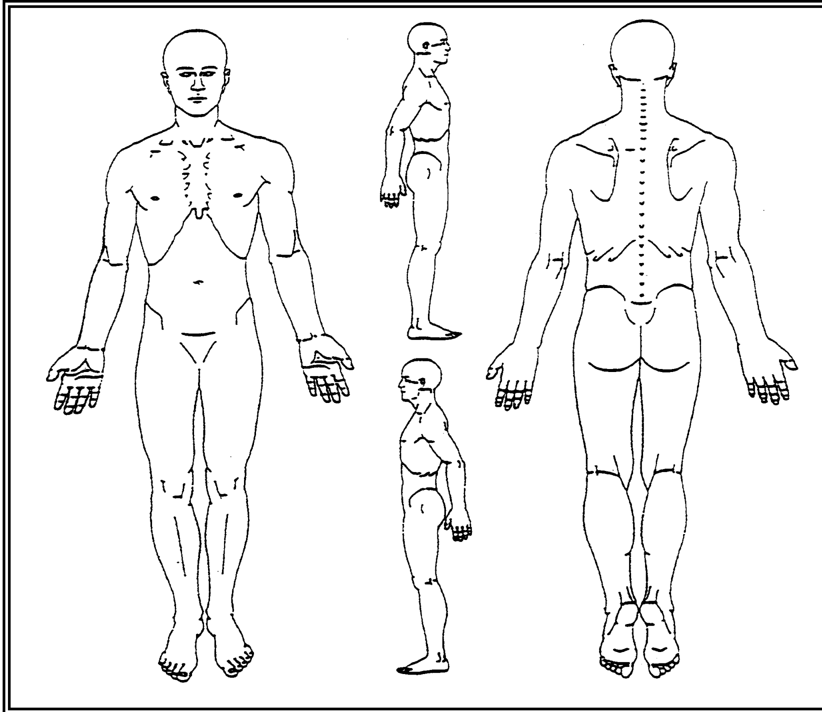
Last Name:

Please indicate the main reason you are seeing us today: ____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Sources of Physiological Stress:

Emotional/Mental	**Physical Trauma/Falls/Accidents**	**Toxins/Chemical Exposure**
__ work environment/employment	__ birth or childhood injuries	__ harsh chemical cleaners
__ home related/kids/family	__ vehicle accidents: yr(s)_________	__ tobacco/alcohol/drug usage
__ relational	__ sports injuries	__ pets and allergies
__ psychological	__ work injuries	__ environmental/building toxins
__ spiritual	__ virus/illness/disease	__ medications ____ yrs
__ other ________________________	__ other ________________________	__ other ________________________

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Medical Symptoms Questionnaire

Patient Name_________________________ **Date** _________

Rate each of the following symptoms based upon your typical health profile for: ☐ Past 30 days ☐ Past 48 hours

Point Scale

0 - Never or almost never have the symptom

1 - Occasionally have it, effect is not severe

2 - Occasionally have it, effect is severe

3 - Frequently have it, effect is not severe

4 - Frequently have it, effect is severe

HEAD	ENERGY/ACTIVITY	LUNGS
_____Headaches _____Faintness _____Dizziness _____Insomnia Total_______	_____Fatigue, Sluggishness _____Apathy, Lethargy _____Hyperactivity _____Restlessness Total_______	_____Chest Congestion _____Asthma, Bronchitis _____Shortness of Breath _____Difficulty Breathing Total_______
EYES _____Watery or Itchy Eyes _____Swollen, Reddened or Sticky Eyelids _____Bags or Dark Circles Under Eyes _____Blurred or Tunnel Vision (does not include near or far-sighted) Total_______	**WEIGHT** _____Binge Eating/Drinking _____Craving Certain Foods _____Excessive Weight _____Compulsive Eating _____Water Retention _____Underweight Total_______	**HEART** _____Irregular or Skipped Heartbeat _____Rapid or Pounding Heartbeat _____Chest Pain Total_______
EARS _____Itchy Ears _____Earaches, Ear Infections _____Drainage from Ear _____Ringing in Ears, Hearing Loss Total_______	**EMOTIONS** _____Mood Swings _____Anxiety, Fear, Nervousness _____Anger, Irritability, Aggressiveness _____Depression Total_______	**DIGESTIVE TRACT** _____Nausea, Vomiting _____Diarrhea _____Constipation _____Bloated Feeling _____Belching, Passing Gas _____Heartburn _____Intestinal/Stomach Pain Total_______
NOSE _____Stuffy Nose _____Sinus Problems _____Hay Fever _____Sneezing Attacks _____Excessive Mucus Formation Total_______ **MOUTH/THROAT** _____Chronic Coughing _____Gagging, Frequent Need to Clear Throat _____Sore Throat, Hoarseness, Loss of Voice _____Swollen or Discolored Tongue, Gums/Lips _____Canker Sores Total_______	**MIND** _____Poor Memory _____Confusion, Poor Comprehension _____Poor Concentration _____Poor Physical Condition _____Difficulty in Making Decisions _____Stuttering or Stammering _____Slurred Speech _____Learning Disabilities Total_______	**OTHER** _____Frequent Illness _____Frequent or Urgent Urination _____Genital Itch or Discharge Total_______
SKIN _____Acne _____Hives, Rashes, Dry Skin _____Hair Loss _____Flushing, Hot Flashes _____Excessive Sweating Total_______	**JOINTS/MUSCLE** _____Pain or Aches in Joints _____Arthritis _____Stiffness or Limited Movement _____Pain or Aches in Muscles _____Feeling of Weakness or Tiredness Total_______	**GRAND TOTAL** _________

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Optional Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, x-ray reports/copies, financial/billing information or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.
Patient Name: ____ Date of Birth: _______________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Lab Reports
- ☐ X-Ray Narrative
- ☐ Billing/Financials
- ☐ Copy of X-Rays (Subject to a $20 fee)
- ☐ Other (Please Specify) ____

____

Release my protected health information to the following physician/person/facility/entity (s) and/or those directly associated in my medical care:

Name: ____
Address: ____
City, State & Zip Code: ____

Name: ____
Address: ____
City, State & Zip Code: ____

Signature: ____
Printed Patient Name: ____
Date: ____

Printed Name of Patient's Personal Representative if applicable: ______________________________
(Must have proof of authorization)
Signature of Personal Representative: ____

Payment information for release of X-Ray copies:
Name on Card ______________________________Billing Address __________________________
____ Type of Credit Card ____________________
Credit Card number ____ Expiration ___________

Revive Chiropractic
260 W. Main St., Suite 211
Hendersonville, TN 37075

615.651.4471
www.revivetn.com
revivetn@gmail.com

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Last Name:

Patient Name____

Financial Responsibility

Natural Healthcare that includes whole food supplementation, exercise and other remedies are not generally covered by third party payers (insurance companies). Revive Chiropractic provides its services directly to you, not to your insurance company. In certain cases, there may be the opportunity for reimbursement. Our financial policy is that fees are paid at the time of service and when products are provided they can be paid for by cash, check, or credit card. However, if applicable, we will provide you with the proper documentation for your reimbursement needs.

I have read and understood all the above information.

__________________________________ __________

Patient Signature Date

X-Ray Consent

_____Check here if you are pregnant or think you may be pregnant at this time.

I hereby give my consent to Revive Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

__________________________________ __________

Patient Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Acknowledgement of Receipt of Privacy Practices

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____

Signature Date

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to realign your spine. We do many gentle chiropractic techniques, though sometimes you may feel a "click" or "pop" and you may feel movement of the joint. The doctor may request x-rays to be taken if necessary after reviewing your case. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscle soreness, fatigue, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. We primarily do not use adjustments to the neck region that involve twisting that would cause this type of injury. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Informed Consent to Chiropractic Treatment

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my consent to treatment.

____

Signature Date

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Hendersonville, TN 37075

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Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to provide you with a complete, detailed disclosure at your request, please understand that we will always respect the privacy of your health information.

I understand that, under the Health Insurance Portability & 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 among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization may need to use my name, address, phone number, e-mail, and clinical records to contact me with appointment reminders, information about treatment alternatives, newsletters, or other health related information that may be of interest to me. I consent to receive communications sent by or on behalf of Revive Chiropractic via regular mail, e-mail, telephone, or fax. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone. By signing this form, I am giving you authorization to contact me with these reminders and information and to leave messages on my answering machine or with individuals at my home or place of employment.

Name ____ Date_________________________________