GATEWAYS CHIROPRACTIC

Account #:________

Name:_______________________________________ Date of Birth:________ Age:___ Today's Date:________

Address:_____________________________________ City:_________________ State:_____ Zip:___________

Home Phone #:_________________ Cell:________________ Email:_________________________________

Occupation:____ Employer:______________________________

Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Partnered ❑Divorced ❑Widowed

Spouse/Partner's Name:_________________________ Date of Birth:________ Occupation:_______________

Names & Ages of Children:____

Emergency Contact:____________________________ Relationship:_____________ Phone #:_____________

How did you hear about us?____

Whom may we thank for your referral?____

Have you seen a chiropractor before? ❑Yes ❑No Office:________________________ Last visit?____________

Reason for Care:___________________________________ Results:___________________________________

YOUR HEALTH PROFILE

What are your current health concerns?
(In order of priority)___________________

____

____

____

When did it start?_____________________

❑ Sudden ❑ Gradual ❑ Recurring

Describe the onset:____________________

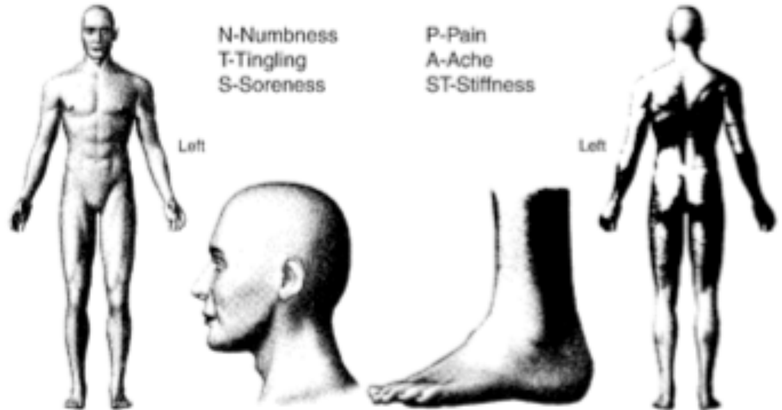
____

Describe the quality of symptoms/pain:_____

____

Please rate the severity of the condition
(0=none, 10=worst imaginable):

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10



Severity at its worst (0-10):______ Severity at its best (0-10):_______

How often do the symptoms/pain occur?______% of day When are symptoms the worst?__________________

Does this condition keep you from doing anything?____

What makes it worse?_____________________________ What makes it better?________________________

Describe prior treatment, diagnoses, interventions, or medications used for this problem and their results:_______

____

Anything else that may be helpful for us to know regarding your current health concern(s): __________________

____

INTERNAL USE ONLY

GATEWAYS CHIROPRACTIC

HEALTH HISTORY

Patient's Name ____ Date of Birth ________________

Have you been diagnosed with any ongoing, unresolved, chronic, or recurring health problems? ❑Yes ❑No
Please explain:____

Are you currently seeing any other healthcare practitioners? Please List:______________________________
____

Please check the appropriate box for all symptoms you have, or have ever had, even if they do not seem related to your current problem. (P = Previous) (C = Current) (Blank/Unmarked = Never)

P C
- ❑ ❑ Stiff, sore joints
- ❑ ❑ Headache
- ❑ ❑ Heartburn
- ❑ ❑ Gas, bloating
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea
- ❑ ❑ Anxiety, irritability
- ❑ ❑ Depression
- ❑ ❑ Restlessness
- ❑ ❑ Insomnia
- ❑ ❑ Fatigue
- ❑ ❑ Anemia

P C
- ❑ ❑ Diabetes
- ❑ ❑ Asthma
- ❑ ❑ Emphysema
- ❑ ❑ Frequent colds/flus
- ❑ ❑ Sinus trouble
- ❑ ❑ Epilepsy
- ❑ ❑ Multiple Sclerosis
- ❑ ❑ Ringing in ears
- ❑ ❑ Blurred vision
- ❑ ❑ Vertigo
- ❑ ❑ Stroke
- ❑ ❑ Urinary Problems

P C
- ❑ ❑ Chest pain
- ❑ ❑ Pacemaker
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ High cholesterol
- ❑ ❑ Aneurysm
- ❑ ❑ Bleeding disorder
- ❑ ❑ HIV/AIDS
- ❑ ❑ Menstrual irregularity
- ❑ ❑ Miscarriage
- ❑ ❑ Infertility
- ❑ ❑ Prostate problems

P C
- ❑ ❑ Scoliosis
- ❑ ❑ Neck pain
- ❑ ❑ Shoulder/arm pain
- ❑ ❑ Numbness in fingers
- ❑ ❑ Cold hands
- ❑ ❑ Mid-back pain
- ❑ ❑ Low back pain
- ❑ ❑ Hip pain
- ❑ ❑ Leg/Foot pain
- ❑ ❑ Numbness in legs/feet
- ❑ ❑ Cold feet
- ❑ ❑ Osteoporosis

P C
- ❑ ❑ Arthritis (type, where?):______________________
- ❑ ❑ Skin problems:____________________________
- ❑ ❑ Gastric/Bowel disease:______________________
- ❑ ❑ Heart disease:____________________________
- ❑ ❑ Respiratory disease:________________________
- ❑ ❑ Cancer:_________________________________

P C
- ❑ ❑ Autoimmune disease:__________________________
- ❑ ❑ Thyroid problems:_____________________________
- ❑ ❑ Kidney disease:_______________________________
- ❑ ❑ Liver disease:________________________________
- ❑ ❑ Genital-Urinary disease:_______________________
- ❑ ❑ Nervous system or Vascular disease:_______________

Are you currently taking any medications or supplements? *Include regularly used over-the-counter medications.*

Name of Medication or Supplement	Dosage	Frequency	Reason for Taking

Please list any allergies you have and your reaction to that substance): ❑ No known allergies
____

Please list any surgeries you have had and the date of surgery: Any implants, pins, or screws? ❑Yes ❑No
______________________________ Date:__________ ______________________________ Date:__________
______________________________ Date:__________ ______________________________ Date:__________

Please list any accidents and/or injuries (automobile, sports, playground, etc.) and the date of injury:
______________________________ Date:__________ ______________________________ Date:__________
______________________________ Date:__________ ______________________________ Date:__________

GATEWAYS CHIROPRACTIC

Patient's Name ____ Date of Birth __________________

FAMILY HISTORY

❑ Diabetes Mother/Father/Brother/Sister/Other:__________
❑ Heart Disease Mother/Father/Brother/Sister/Other:__________
❑ Cancer Mother/Father/Brother/Sister/Other:__________ Type:____________
❑ Arthritis Mother/Father/Brother/Sister/Other:__________ Type:____________
❑ Multiple Sclerosis Mother/Father/Brother/Sister/Other:__________
❑ Other:__________ Mother/Father/Brother/Sister/Other:__________

FOR WOMEN:

Are you pregnant? ❑Yes ❑No Date of Last Menstrual Period:________________
If pregnant, what is your "guess date"?_______________ Name of OB/GYN or Midwife:________________
Where will you be birthing your baby? ❑Hospital ❑Home ❑Birthing Center ❑Other:__________________

"GATEWAYS TO HEALTH"

At Gateways Chiropractic, we approach your care by finding and addressing your unique **"Sources of Stress.**" We strive to uncover the underlying, **root cause** of your health concerns and work to "**connect the dots**" of your health puzzle so that we can best serve you and help you to reach your health goals.

What are your current health & wellness goals (long and short term)?___________________________________
____
Please rate your overall health & wellness: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Please rate your average stress level: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
How would you describe your current health?____
How would you describe your family's health?____
What are your major sources of stress (physical, emotional, and/or nutritional/chemical):__________________
____
How do you manage stress?____
Is your health better, worse, or the same as 5 years ago? Why do you think this is?______________________

Typical Daily Activities:_______________________________________ Hobbies:_____________________
Exercise: ❑None ❑Light ❑Moderate ❑Active ❑Very Active Type:__________________ Frequency:_______
Habits: ❑ Smoking (___ packs/day) ❑ Alcohol (____ drinks/day) ❑ Caffeine (type:________ #/day_____)
❑ Soda ❑ Diet Soda ❑ Artificial Sweeteners ❑ Fast Food

NUTRITION

Food sensitivities (known or suspected):____
Food allergies:____
Foods you crave:____
Foods you avoid (and why):____
Diets or dietary guidelines you follow:____

INTERNAL USE ONLY

GOALS AND EXPECTATIONS

Patient's Name ____ Date of Birth _________________

We offer several types of holistic, natural healthcare at our office. Please mark which types of care you are interested in:

- ❑ **Chiropractic Care** – spinal-specific adjustments to address structural stress and nervous system health
- ❑ **Acupuncture** – the use of needles, gentle electric stimulation, or both, to assist with the balance and circulation of energy in the body; commonly used to alleviate pain and assist in treating numerous conditions
- ❑ **Nutritional Coaching & Digestive Health Consultation** – this may include a full functional health examination and the recommendation of enzyme nutrition, nutritional changes, lifestyle changes, and other supplementation.
- ❑ **Unsure** – I would like the doctor to select the type of care that is most appropriate for my condition

People visit a chiropractor for a variety of reasons. In order to better serve you, we'd like to know which of the following healthcare options you are most interested in and intend to follow:

- ❑ **Preventive Care** – wellness and life-enhancement care (pro-active health empowerment)
- ❑ **Maintenance Care** – removing symptoms and their cause with periodic routine maintenance
- ❑ **Relief Care** – remove acute symptoms only; short-term relief
- ❑ **Unsure** – I would like the doctor to select the type of care that is most appropriate for my condition

CONSENT

I consent to a complete chiropractic & functional health examination and any further testing (urinalysis, blood work, radiographs) that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. Today's visit is NOT for a work-related injury or accident.

____ ________________________

Patient/Guardian Signature Date

OFFICE POLICIES

Accepting New Patients – the doctors at Gateways Chiropractic reserve the right to accept or decline any case or new potential patient at the office.

Lengthy or Confidential Questions – if you have any lengthy or confidential questions to discuss with the doctor, we will be happy to have the doctor call you or arrange a special appointment for a private consultation.

Missed Appointments – if for any reason you must miss your scheduled appointment, please call as soon as possible so that your appointment may be rescheduled so that your health goals can be reached. If you miss your appointment and do not call that day, Gateways Chiropractic reserves the right to charge a fee of $25 to your account at the end of that business day.

Cell Phone Policy – To ensure a peaceful, relaxing, and healing environment, please place cellular phones and other electronic devices on vibrate or silent and refrain from cell phone use in our office.

Severe Weather – The office may close in the event of severe weather. In the case of extreme weather conditions, please call first to be sure the office is open.

I have read and understand the above policies.

____ ________________________

Patient/Guardian Signature Date

GATEWAYS CHIROPRACTIC

FINANCIAL POLICY & AGREEMENT

Patient's Name ____ Date of Birth __________________

Your health is our primary concern. Our recommendations are based on a desire to see you get well and stay well. We will suggest the chiropractic care and other treatments that we believe you need to reach your health goals. We ask that you read and understand our financial policy as it applies to your particular situation.

As healthcare providers, our relationships with our patients are of the utmost importance. We offer a unique perspective on health and healing that is quite different from the mainstream allopathic/medical approach. Because we focus on functional health and a preventative, holistic approach to healthcare, our core values are not aligned with those of insurance companies. For these reasons, and in an effort to provide the best possible care to our patients and to keep our prices fair and reasonable, Gateways Chiropractic, LLC is out-of-network with insurance companies (with the exception of Medicare). We are happy to provide you with the billing information you will need to submit to your insurance company for out-of-network benefits and reimbursement. We have a relationship with you, our patient, and not your insurance company. We are not responsible for, and cannot guarantee, reimbursement or payment to you by your insurance company.

In the event that you default in your financial and/or care agreement with us, the professional services being provided to you and your family will stop until all deficiency balance has been brought current. If you suspend or terminate care as prescribed by the doctors at Gateways Chiropractic, LLC, any remaining balance will be due and payable immediately.

Full payment is due at the time of service. We accept cash, check, and credit cards.

MEDICARE

Medicare only covers manual manipulation of the spine for acute conditions. All other services are *NON-COVERED*. These services include, but are not limited to: examinations, therapies, acupuncture, therapeutic exercise, orthotics, supports, nutritional supplements, x-rays, and/or wellness adjustments. We *DO NOT* accept assignment from Medicare. This means that the patient is responsible for paying at the time of service.

I have read and understand the financial policy of Gateways Chiropractic, LLC. I understand that I am financially responsible for the care I receive at Gateways Chiropractic, LLC. I understand that full payment is due at the time of service (cash, check, and credit cards are accepted).

______________________________________ __________________________

Patient/Guardian Signature Date

HIPAA/NOTICE OF PRIVACY PRACTICES

GATEWAYS CHIROPRACTIC

GATEWAYS CHIROPRACTIC

Patient's Name ____ Date of Birth ________________

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

SPECIFIC AUTHORIZATIONS

- I give permission to use my address, phone number, email, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday cards, newsletters, and information about health-related information and Gateways Chiropractic.
- If Gateways Chiropractic contacts me by phone, I give them permission to leave a message on my answering machine/voicemail or to send me a text message.
- I give Gateways Chiropractic permission to use any testimonial written by me for promotional, educational, and informational purposes.

EXPIRATION This authorization shall expire on the following date: *ongoing*

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Gateways Chiropractic, LLC. The written notice must contain the following information:

Your name, Social Security number, and date of birth;
A clear statement of your intent to revoke this authorization;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

By signing this form, you are giving Gateways Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

______________________________ ______________________
Patient/Guardian Signature Date

GATEWAYS CHIROPRACTIC

INFORMED CONSENT

Patient's Name ____ Date of Birth ____________________

When a patient seeks chiropractic care, acupuncture, or other natural, holistic, or alternative healthcare, and we accept a patient for such care, it is essential for both parties to be working towards the same objective. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo care at our office.

CHIROPRACTIC is the science and art which concerns itself with the relationship between physical structure (the spine) and function (the nervous system) as that relationship may affect health. **HEALTH** is a state of optimal physical, mental, and social well-being, not only the absence of sickness, disease, or symptoms.

One disturbance to the nervous system is called a **VERTEBRAL SUBLUXATION**. This occurs when one (or more) of the 24 bones in the spine do not move properly and/or become mis-aligned. This causes alteration in nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected by a **CHIROPRACTIC ADJUSTMENT**. An adjustment is a specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine or other joints. Adjustments are usually done by hand but may be performed with a hand-held instrument. Adjustments may cause an audible "pop" or "click." You may feel a sense of movement.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another healthcare provider.

ANALYSIS/EXAMINATION/TREATMENT
As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- ▫ chiropractic adjustments
- ▫ palpation
- ▫ vital signs
- ▫ range of motion testing
- ▫ orthopedic testing
- ▫ basic neurological testing
- ▫ muscle strength testing
- ▫ postural analysis
- ▫ electric muscle stimulation
- ▫ ultrasound
- ▫ hot/cold therapy
- ▫ acupuncture

RISKS
As with any healthcare procedure, there are certain risks which may arise during chiropractic adjustments and therapies. Some patients will feel some stiffness and soreness following the first few days of treatment. Other complications are rare and include but are not limited to: muscle strain, fractures, disc injuries, dislocations, and sprains. In exceedingly rare instances, with some types of manipulation of the neck, there has been an association with injuries to the arteries in the neck, contributing to serious complications including stroke. The incidences of stroke are estimated to occur between one in one million and one in five million cervical adjustments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that any questions I had have been answered to my satisfaction and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

____ ________________________
Patient/Guardian Signature Date