

High Point Chiropractic Health Profile

Name _____ Date _____ / _____ / _____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Date of Birth _____ / _____ / _____

Who may we thank for referring you? _____ Email Address _____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

 **LIST YOUR HEALTH CONCERNS BELOW**

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _____ MEDICAL DOCTOR? _____ OTHER _____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	NERVOUSNESS
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	EPILEPSY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	DISC PROBLEM
EAR INFECTIONS	ULCERS	SCIATICA	LUPUS	INFERTILITY
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	FIBROMYALGIA	GASTRIC REFUX
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	BLADDER PROBLEMS
NECK PAIN	MENSTRUAL DISORDER	LOW BACK PAIN	ARM PAIN	CHRONIC SINUS
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	OTHER _____
ANXIETY	STOMACH DISORDERS	LEG PAINS	KNEE PAIN	_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

Consultation Completed By: _____

Evaluation Cost (If Applicable): _____

LIST ALL SURGICAL OPERATIONS AND YEARS _____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

WHEN WAS YOUR LAST AUTO ACCIDENT _____ ?

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA: _____

SOCIAL HISTORY

1. SMOKING: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never

2. EXERCISE: How often? Daily Weekends Occasionally Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES - EXERCISE**

4. WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:

Carrying/Lifting Groceries	Driving	Reading/Concentration	Sexual Activities
Sitting to Standing	Extended Computer Use	Sweeping/Vacuuming	Sleep
Climbing Stairs	Garbage	Dressing	Static Sitting
Pet Care	Lifting Children	Shaving	Static Standing
Yard Work	Walking	Bathing	
Laundry	Dishes		
Other: _____			

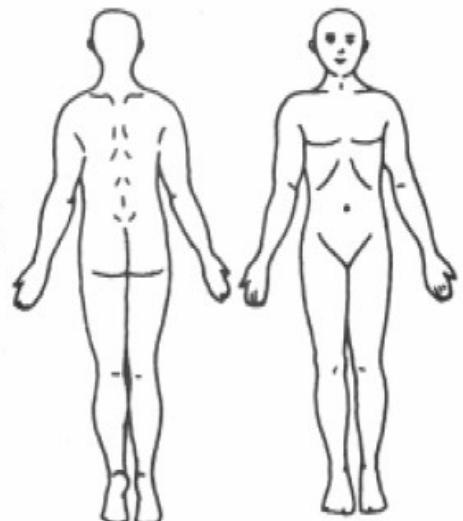
*PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness

S = Sharp/ Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



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 SECONDARY 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 PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE

DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. WESTON NEMITZ AND ANY AND ALL HIGH POINT CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, 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 HIGH POINT CHIROPRACTIC.

DATE

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR / CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE

TERMS OF ACCEPTANCE

In order to provide for 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 question 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 type(s) 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
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

Please opt me out of receiving text email

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 information 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 physicians 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 disclosed 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)

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST _____ MIDDLE _____ LAST _____

SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured _____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured _____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation** - includes practice member history.
- **Assessment (new or established practice member)** - includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check.
- **Chiropractic Adjustment** - The actual re-alignment of the vertebral misalignments. Often a sound will be heard, but if there is no auditory component, it does not mean that the adjustment has not taken place.
- **X-rays** - Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Weston Nemitz, DC. 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.

Signed _____ Date _____

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 IS \$15 AND WILL BE MAILED UNLESS OTHERWISE SPECIFIED. 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. DR. WESTON NEMITZ OF HIGH POINT CHIROPRACTIC DOES 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.

PRINT YOUR NAME HERE

DATE

SIGNATURE

YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT
AT THE TIME X-RAYS ARE TAKEN AT HIGH POINT CHIROPRACTIC.

SIGNATURE

DATE

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: M F

<input type="checkbox"/> Lat Cervical <input type="checkbox"/> Flex/Ext CM Kvp Time MAS □10-11 □78 □1/24 12.5 □12-13 □ □1/20 15 □14-15 □ □1/15 20 □16-17 □1/10 30 □2/15 40 MA 300 Size 8x10	<input type="checkbox"/> Lower Cervical CM Kvp Time MAS □14-15 □70 □1/10 20 □16-17 □ □2/15 30 □18-19 □3/20 40 □20-21 □2/10 50 □22-23 MA 300 Size 8x10	<input type="checkbox"/> Lateral Thoracic CM Kvp Time MAS □22-23 □80 □1/15 20 □24-25 □ □1/10 30 □26-27 □2/15 40 □28-29 □2/10 50 □30-31 □1/4 75 □32-33 □3/10 90 □34-35 □2/5 120 □36-37 □1/2 150 MA 300 Size 14x17	<input type="checkbox"/> A-P Thoracic CM Kvp Time MAS □16-17 □75 □1/20 17 □18-19 □ □1/15 22 □20-21 □1/10 30 □22-23 □2/15 40 □24-25 □2/10 50 □26-27 □1/4 75 □28-29 □3/10 90 □30-31 □2/5 120 MA 300 Size 14x17
<input type="checkbox"/> APOM CM Kvp Time MAS □14-15 □70 □1/10 20 □16-17 □ □2/15 30 □18-19 □3/20 40 □20-21 □2/10 50 □22-23 MA 300 Size 8x10		Other View _____ CM _____ Kvp _____ MAS _____ MA _____ Size _____	
Notes: _____ _____ _____ _____ _____ _____		<input type="checkbox"/> Lateral Lumbar CM Kvp Time MAS □26-27 □88 □2/10 30 □28-29 □90 □1/4 40 □30-31 □92 □3/10 50 □32-33 □94 □2/5 70 □34-35 □96 □1/2 90 □36-37 □ □3/5 120 □38-39 □4/5 160 □40-41 □1 200 □42-43 □1 1/2 □2 MA 200 Size 14x17	
		<input type="checkbox"/> A-P Lumbar CM Kvp Time MAS □20-21 □76 □1/15 40 □22-23 □78 □1/10 50 □24-25 □80 □2/15 75 □26-27 □ □2/10 90 □28-29 □1/4 120 □30-31 □3/10 150 □32-33 □2/5 120 □34-35 □1/2 170 □36-37 □3/5 210 □38-39 □4/5 □40-41 □1 □42-43 □1 1/2 □2 MA 300 Size 14x17	

CA Initials:

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE

PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

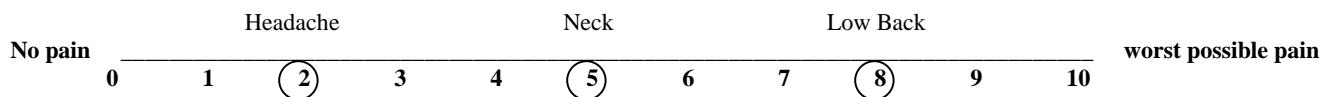
Date _____

Please read carefully:

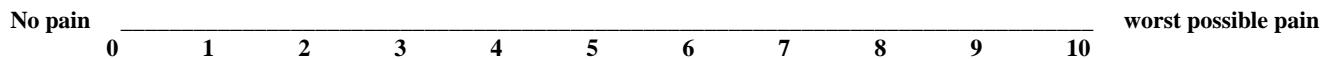
Instructions: Please circle the number that best describes the question being asked.

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.

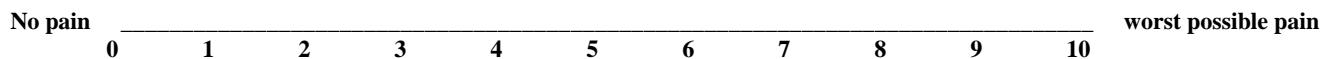
Example:



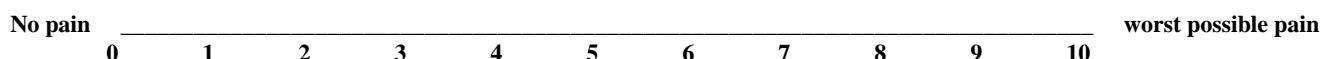
1 – What is your pain **RIGHT NOW?**



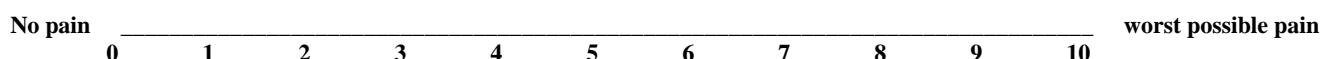
2 – What is your TYPICAL or AVERAGE pain?



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



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



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.