Inspire Life Chiropractic

ADULT HISTORY FORM

Personal Information

Legal Name:_____ Date:_____/_____/_____

Address:_____ Home Phone:_____

_____ Cell Phone:_____

_____ Work Phone:_____

Birth Date:_____/_____/_____ Please circle one: Male/ Female / Non-binary Married / Single /Widowed / Divorced

How did you hear about us? _____ Email Address:_____

Number of Children& Ages:_____ Other family member's names:_____

Emergency Contact Name:_____ Phone:_____ Relation: _____

Insurance Information

(Please give your insurance card and driver's license to the front desk for a complimentary benefits evaluation)

Primary Insurance Carrier:_____ Subscriber's Name:_____

Occupation:_____ Employer:_____

Subscriber's S.S. # _____ Birth Date: _____/_____/_____

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to the doctors. 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.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Have you ever been to a Chiropractor before? Y / N When was your last visit?.

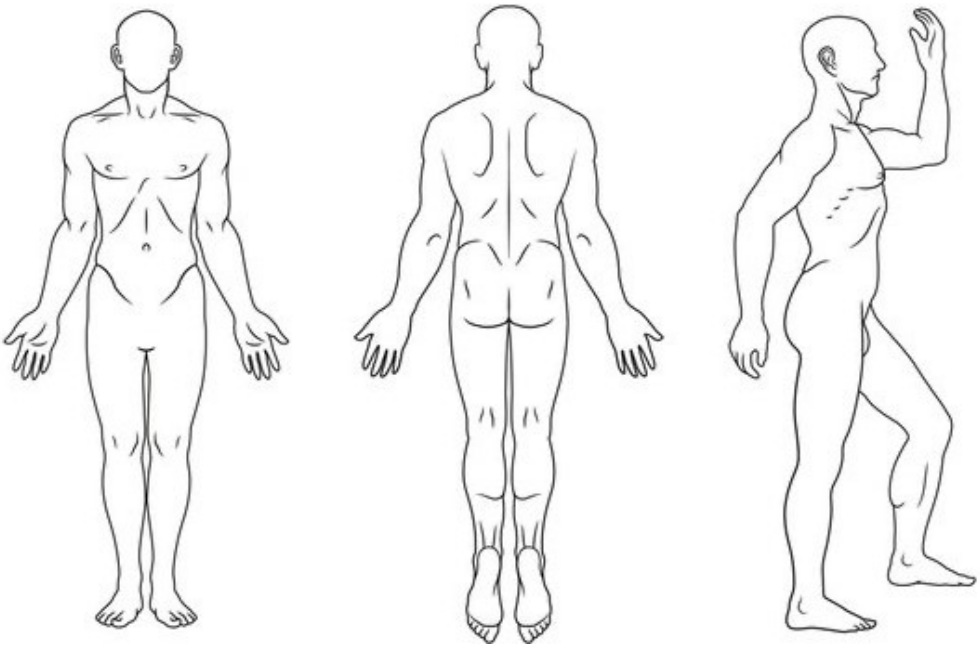
Health Concerns:

Health Concerns: In Order of Importance	Severity:1=Mild 10=Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Constant or Comes/Goes?
1) _____	_____	_____	_____	Y / N	_____
2) _____	_____	_____	_____	Y / N	_____
3) _____	_____	_____	_____	Y / N	_____
4) _____	_____	_____	_____	Y / N	_____

Staff Notes:

Please Mark the areas on the body diagram with the following letters.

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



How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?

_____

_____

_____

_____

Did you know: the head weighs 10-14 lbs& rests on a 2 oz bone called the atlas

Main Complaint History:

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No

Describe: _____

_____

3. How often is this present?

☐ Constant (81 – 100%) ☐ Frequent (51 – 80%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise(Moving) ☐ Lying Down ☐ Other

If other, please explain: _____

_____

6. When is the problem at its worst? ○AM ○PM ○Mid-day ○Late PM

7. What relieves your Symptoms?_____

_____

8. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _____

_____

How long were you under care: _____ What were the Results? _____

9. Please list all medications you are taking and for what: _____

_____

10. Please list any broken/fractured bones, surgeries or hospitalizations you have had and when:

_____

_____

11. Please list any auto accidents or injuries you have been involved in:

_____

LIST RESTRICTED ACTIVITY	_CURRENT ACTIVITY LEVEL__	__USUAL ACTIVITY LEVEL___
_____	_____	_____
_____	_____	_____
_____	_____	_____
__(Example: Climbing stairs_____	_____climbing 2 flights before it hurts____	_I used to climb 10+flights without pain)_

Did you know: the head weighs 10-14 lbs& rests on a 2 oz bone called the atlas

Please check off any of the conditions below that you (or your family) have or have had in the past:
-- Write C if current issue or P if past issue

	Yourself	Spouse	Children	Mother	Father
Acid Reflux					
Arthritis					
Asthma					
Cardiac Condition					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting					
Fatigue					
Headaches					
Hip Pain					
Irritable Bowel					
Kidney Condition					
Knee Pain					
Liver Disease					
Low Back Pain					
Lupus					
Menstrual Irregularity					
Mid Back Pain					
Migraines					
Nausea					
Neck Pain					
Nervousness					
Numbness					
Sciatica					
Shoulder Pain					
Sinus					
Stiffness					
Stomach Condition					
TMJ					
Ulcers					
Upper Back Pain					
Vertigo					

Initials: _____ Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐Unable to Perform

Initials: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

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 average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

			headache		neck					low back		
no pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

##########

1. What is your pain RIGHTNOW?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

2. What is your TYPICAL or AVERAGE pain?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

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

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

What percentage of your awake hours is your pain at its best? %

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

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**worst possible pain**

What percentage of your awake hours is your pain at its worst? %

NAME_____ **AGE** _____ **DATE**_____ **SCORE**

SCORE: #1_____ #2 _____#4_____=_____/ 3 x10=_____(Low intensity = <50; High intensity =>50)

PICTURE/VIDEO CONSENT FORM

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Inspire Life Chiropractic, or anyone authorized by Inspire Life Chiropractic, of any and all photographs/videos/Success stories which you have this day taken of _____, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Inspire Life Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Inspire Life Chiropractic to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Name (printed): _____ Date: _____

Signature: _____ Date: _____

Thank you for sharing your chiropractic story!

By sharing your story, you are impacting many people and showing them that there is HOPE through principled chiropractic!

RECORDS RELEASE AUTHORIZATION FORM

According to The Health Insurance Portability and Accountability Act (HIPAA), Inspire Life Chiropractic is required by law to maintain confidentially in regards to any private health information regarding you or your child's care unless given specific permission to do otherwise. If you would like us to be able to share you or your child's private health information with a spouse, loved one, or any other person, please fill out the form below.

I, _____ (print name) authorize Inspire Life Chiropractic. to release confidential information regarding diagnostic assessments, x-rays, medical records, findings, billing information, and/or recommendations for _____(patient name or self) to the following people:

Name: _____Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that if any of the information above changes, it is my responsibility to inform Inspire Life Chiropractic. and fill out an updated records release form.

Patient Signature: _____Date:_____

Inspire Life Representative: _____Date: _____

Did you know: the head weighs 10-14 lbs& rests on a 2 oz bone called the atlas

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 physician's 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 do agree, then you are bound to abide by such restrictions.

Signature _____ 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 THE X-RAYS IN OUR FILES.

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 DOCTOR OF INSPIRE LIFE 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

PRINTED NAME _____ _____ 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 INSPIRE LIFE CHIROPRACTIC.

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE

Did you know: the head weighs 10-14 lbs& rests on a 2 oz bone called the atlas

WRITTEN CONSENT FOR A CHILD/MINOR

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

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. MCCARTNEY GOFFAND ANY AND ALL INSPIRE LIFE CHIROPRACTICSTAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE 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 INSPIRE LIFE CHIROPRACTIC.

Guardian Signature _____ Date _____

Guardian's Relationship to Minor/Child _____

Witness Signature (Office Staff) _____

Did you know: Research shows adjustments help calm the nervous system