JAQUA
CHIROPRACTIC

Please print clearly and fill in completely

Print Name _____ **Email** _____

Street Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Do you have insurance that you believe may cover part of your chiropractic care? No ❑ Yes ❑

Name or type of insurance: _____

Health History:

What reason are you seeking chiropractic care today?:_____

_____

Please describe any current health problems and how long you've had them: _____

_____

Are you under the care of any other doctor? No ❑ Yes ❑ If Yes, please explain conditions being treated for:

_____

Are you currently taking any medications? No ❑ Yes ❑ If Yes, please list: _____

_____

Please list any allergies: _____

Please list any past surgeries & dates: _____

Please list any past accidents & tests:_____

Please list any x-rays you've had in the past 2 years: _____

If applicable, is there a possibility that you might be pregnant (females only): No ❑ Yes ❑

Personal/Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

Have you ever been to a Chiropractor before? No ❑ Yes ❑ If yes, Doctor's Name_____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays_____ How long were you under care? _____

Are other family members under chiropractic care? No ❑ Yes ❑ Who?_____

Rate Your Overall Health

To better help us understand your overall health goals and your current situation, please **circle** what you feel is your current level of health and wellness, on a scale from 0% to 100%: **10%- 20%-30%- 40%-50%-60%-70%-80% -90%-100%**

Refferals

Who referred you, or where you hear about our clinic? _____

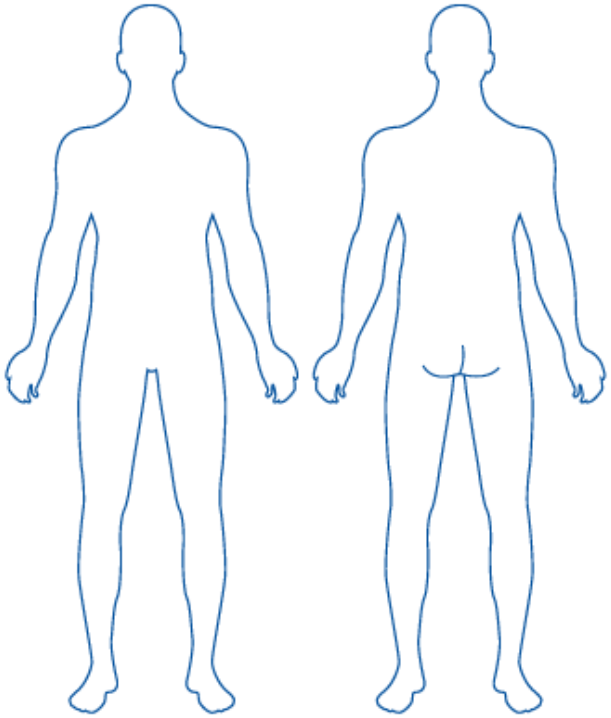
❑ Facebook ❑ Web Search ❑ Saw ad in _____ ❑ Saw sign driving by ❑ Other: _____

Please Fill in Below

If you currently or recently have suffered from any of the following, ***Please Check*** ✓

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other Joint Pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent Colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest Pains	❑	❑
Female Problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin Conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your care.

_____

_____

_____

_____

_____

_____

_____

_____

Your Signature: _____

Date:_____

JAQUA
CHIROPRACTIC

Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality Chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your God-given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions please feel free to ask us.

I wish to initiate care in the form of examination procedures at Jaqua Chiropractic. I understand that I am under no obligation to either receive any further care unless I agree to such care at my report of findings.

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 or disclosed to carry out treatment, payment, or healthcare operation. 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.

Today's date _____

Print your name _____

Sign your name_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand that Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Today's date: _____

Patient's Full Name (Printed): _____

Patient's Signature: _____

Parent, Guardian or Patient's legal representative: _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize this practice to release PHI:

_____ _____

_____ _____

_____ _____

_____ _____

JAQUA
CHIROPRACTIC

Patient Authorization Form

If it becomes necessary, I hereby authorize you to use or disclose the specific information described below, only for the purpose described below.

Description of the specific information to be used or disclosed:

_____

_____

_____

_____

_____

This information is being requested for the following purpose(s):

_____

_____

_____

_____

_____

This authorization shall remain in effect for 1 year from the date signed below, unless otherwise stated below.

_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address below, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

Today's date: _____

Patient's Full Name (Printed): _____

Patient's Signature: _____

Relationship to Patient, if representing: _____