

# 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%**

## Referrals

Who referred you, or where you hear about our clinic? \_\_\_\_\_

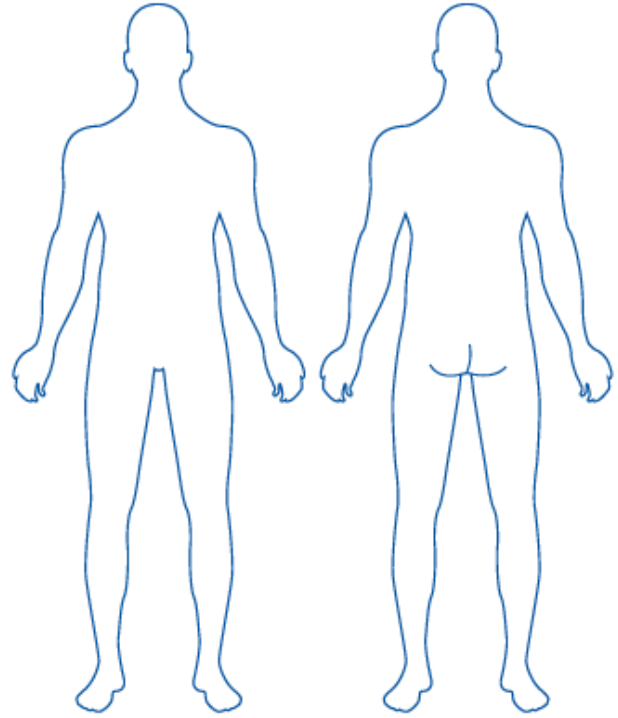
Facebook  Web Search  Saw ad in \_\_\_\_\_  Saw sign driving by  Other: \_\_\_\_\_

**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	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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.

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**Your Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **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. If you have any questions please feel free to ask us.

I wish to initiate care in the form of examination procedures and Chiropractic adjusting techniques at Jaqua Chiropractic.

**Today's date** \_\_\_\_\_

**Print your name** \_\_\_\_\_

**Sign your name** \_\_\_\_\_



**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 received your 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 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. I understand that this form will be placed in my patient chart 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:

_____	_____
_____	_____
_____	_____
_____	_____



## **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:

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

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

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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): \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Relationship to Patient, if representing: \_\_\_\_\_