



# Sea Change

Family Chiropractic, PLLC

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## Welcome to Sea Change Family Chiropractic!

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health.

When a person seeks our care and when we accept a patient for such care, it is essential that we are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness.

Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care, and is necessary in emergency situations.

Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do in our office.

The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. The presence of vertebral subluxation complex is where the transmission of normal nerve impulses have been negatively affected by, and also causing loss of normal spinal biomechanics. These are referred to as subluxations. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information you provide on the following pages is vitally important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, \_\_\_\_\_, have read the above, understand it.

# CONFIDENTIAL PATIENT INFORMATION

## Personal Information

|   |      |   |     |
|---|------|---|-----|
| Full name:  |      | Date:   |     |
| Address:  |      |   |     |
| Street  | City | State   | Zip |
| Home phone:   |      | Work phone:   |     |
| Cell phone:   |      | Email address:  |     |
| Best time/way to contact you:   |      |   |     |
| Date of birth:     /     /  |      | Age:                      Social Security #:                          |     |
| No. of children:  |      | Pregnant?    Yes <input type="checkbox"/> No <input type="checkbox"/> |     |
| Height:   |      | Weight:   |     |
| Marital status:   Married   Single   Widowed   Divorced   Partnered   |      | Spouse/Guardian name:   |     |
| Occupation:   |      |   |     |
| Employer's name & address:  |      |   |     |
| Name of person responsible for account:   |      |   |     |
| Do you have insurance?   Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please present your insurance card to us to copy</i> |      |   |     |
| Plan Subscriber:  |      | Date of birth:     /     /  |     |
| Relationship:   |      |   |     |
| Subscriber ID number:   |      | Plan ID number:   |     |

Who may we thank for referring you? \_\_\_\_\_

## Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".*

## Health Concerns

| Please list your health concerns according to their severity | Rate of severity<br>1 = mild<br>10 = worst imaginable | When did the most current episode start? | When was the first time you <b>EVER</b> recall having this problem? | Did the problem begin with an injury? | % of the time pain is present |
|--|---|--|---|---------------------------------------|-------------------------------|
| 1.   |   |  |   |                                       |                               |
| 2.   |   |  |   |                                       |                               |
| 3.   |   |  |   |                                       |                               |

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

\_\_\_\_\_

Since the problem started is it:    About the same?                       Getting better?                       Getting worse?

What have you done for this condition? Was it of benefit?

\_\_\_\_\_

I do (do not) have a family history of this or similar symptoms (Please explain):

\_\_\_\_\_

Which activities aggravate your condition  Sitting  Standing  Changing Position  Walking  Bending  Lifting/Twisting  
 Driving  Sneezing/Coughing  Computer Work  Other: \_\_\_\_\_

Other providers you have seen for this condition:

|  |                          |
|--|--------------------------|
| "Limited Scope" Chiropractor (focuses mainly on neck and back pain)  | <input type="checkbox"/> |
| "Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) | <input type="checkbox"/> |
| Medical Doctor   | <input type="checkbox"/> |
| Acupuncturist  | <input type="checkbox"/> |
| Physical Therapist or Other (please describe)  | <input type="checkbox"/> |

Primary Care Doctor's details:

|                              |                          |
|------------------------------|--------------------------|
| Name:                        | Address:                 |
| When did you last see them?  | Date of last blood work: |
| What did they say was wrong? |                          |
| Did it help?                 | What did they do?        |

Specialist's details:

|                              |                                     |
|------------------------------|-------------------------------------|
| Name:                        | Address:                            |
| When did you last see them?  | Date of last blood work or testing: |
| What did they say was wrong? |                                     |
| Did it help?                 | What did they do?                   |

**General Health History**

*Accumulation of life's stress can lead to health problems and influence our ability to heal. Please fill out fully - it will help us help you!*

Have you had any surgery? (Please include all surgery)

|          |       |        |
|----------|-------|--------|
| 1. Type: | When? | Doctor |
| 2. Type: | When? | Doctor |
| 3. Type: | When? | Doctor |
| 4. Type: | When? | Doctor |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

|          |       |  |
|----------|-------|--|
| 1. Type: | When? | Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Type: | When? | Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Type: | When? | Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> |

Have you ever had x-rays, MRIs, CT scans, DEXA (bone density) scans taken or EMG/NCV performed?

|               |       |        |
|---------------|-------|--------|
| Area of body: | When? | Where? |
| Area of body: | When? | Where? |
| Area of body: | When? | Where? |

Is this condition interfering with any of the following:

|                               |                                |  |  |  |
|-------------------------------|--------------------------------|--|--|--|
| Work <input type="checkbox"/> | Sleep <input type="checkbox"/> | Daily routine <input type="checkbox"/> | Sports/exercise <input type="checkbox"/> | Other <input type="checkbox"/> (please explain): |
|-------------------------------|--------------------------------|--|--|--|

What do you do most of the day in your job postures, positions, and repetitive movements:

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**Current Medicines and Supplements**

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

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## Past Health History

Please mark the following conditions. **Mark an "N"** for conditions you have NOW. **Mark a "P"** for those you have had in the PAST.

|  |   |                                       |   |  |  |
|--|---|---------------------------------------|---|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Allergy            | <input type="checkbox"/> Anemia       | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Cold Sores   | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Gout              | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV (Aids)            |
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Low Blood Sugar    | <input type="checkbox"/> Malaria      | <input type="checkbox"/> Measles          | <input type="checkbox"/> Menstrual Cramps    | <input type="checkbox"/> Migraines             |
| <input type="checkbox"/> Miscarriage       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Neuritis              |
| <input type="checkbox"/> Pleurisy          | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Polio        | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Whooping Cough        |

Other (please explain): \_\_\_\_\_

## Stressors

Every trauma (slips, falls, accidents, injuries, emotional traumas, ect.) large or small affects our spine and nervous system in some way. Please give a brief description of any significant injuries or accidents over the course of your life, whether or not you think they are related to your spine:

1. Physical stress (falls, accidents, work postures, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

On a scale of 1-10 with 1=Poor and 10=Excellent, please grade how well you think you are doing in the following categories:

|           |               |       |               |        |
|-----------|---------------|-------|---------------|--------|
| Exercise: | Energy level: | Diet: | Stress Level: | Sleep: |
|-----------|---------------|-------|---------------|--------|

Is there anything else which may help to better understand you which have not been discussed?

\_\_\_\_\_

\_\_\_\_\_

On a scale of 1-10, with 10 being the highest, rate your level of commitment to resolving this problem: \_\_\_\_\_

Please list any concerns you may have about getting this problem corrected:

\_\_\_\_\_

I consent to a professional and complete chiropractic examination and to any radiographic examination 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.

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Please initial after each statement.**

I recognize and accept complete financial responsibility for any balance remaining after the payment of any correct benefits by an insurance company. If an unpaid balance remains, I agree to pay reasonable costs and expenses of collections. \_\_\_\_\_

I understand that nutritional supplements that are sold in this office will not be billed to my insurance company. I understand that rehabilitation materials are my sole financial responsibility and will not be released without payment. \_\_\_\_\_

When applicable, I assign insurance benefits for all services rendered by permitting payment directly to Sea Change Family Chiropractic, for services rendered. \_\_\_\_\_

Payment is accepted by cash, check, and/or credit card. There will be up to a \$50 charge for returned checks. \_\_\_\_\_

**We ask to keep your credit card number or Health Savings Account number on file to guarantee appointment attendance, co-pays, and deductibles. Your credit card will be automatically charged for the balance of any outstanding accounts (including service charges, co-pays, and deductibles) that are delinquent beyond 30 days unless a prior arrangement is agreed upon with this office.**

**VISA, MC, Discover, AmEx (circle one) Name on Card** \_\_\_\_\_

**Card #** \_\_\_\_\_ **Exp. Date** \_\_\_\_\_

**Verification Code** \_\_\_\_\_

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

**Printed Name of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient and/or Legal Guardian** \_\_\_\_\_

## **Cancellation Policy**

Success in transforming your health while engaging in chiropractic care is of the utmost importance to us. In order for your care to be successful, your attendance is imperative. In an effort to accommodate your schedule, as well as others that may be waiting for an appointment, our policy is that you contact our office at least 24 hours prior to your appointment to cancel or reschedule. We will make every effort to reschedule your appointment and keep you on track with your treatment plan. A \$50 fee will be assessed for each appointment that I schedule but do not attend. We reserve the right to waive such fees as a courtesy in the event of special circumstance, or if we are able to reschedule your appointment within one week. I have read, understand and agree to the Sea Change Family Chiropractic Cancellation Policy.

**Printed Name of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient and/or Legal Guardian** \_\_\_\_\_

## **Policies & Procedures**

### **Authorization for Medical Information Release**

I authorize Sea Change Family Chiropractic to furnish my insurance company with medical information they may request regarding my condition or treatment. I authorize all of my health care providers to release any treatment notes, diagnostic reports and/or surgery reports to Sea Change Family Chiropractic. Furthermore, I authorize Sea Change Family Chiropractic to release any treatment reports to a referring and/or co-treating physician as it corresponds with my chiropractic care. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Sea Change Family Chiropractic will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. Images that identify me will be released and/or used outside the practice only upon written authorization from me or my legal representative.

**Printed Name of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient and/or Legal Guardian** \_\_\_\_\_

**Privacy Notice & Patient Bill of Rights** (*see HIPAA form on website, or review hard copy in our office*)

I have read and understand the Sea Change Family Chiropractic Notice of Privacy Practices and Patient Bill of Rights.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Designated persons to aid in patient care or to communicate medical information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Printed Name of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Patient and/or Legal Guardian** \_\_\_\_\_

# Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: \_\_\_/\_\_\_/\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): \_\_\_\_\_

| Family Medical History ( <i>Record one diagnosis in your family history and the affected</i> ) |        |        |                     |                       |
|--|--------|--------|---------------------|-----------------------|
| Diagnosis<br>(Write in below)  | Father | Mother | Sibling:<br>(_____) | Offspring:<br>(_____) |
| <i>Example:<br/>Heart Disease</i>  |        | X      |                     |                       |
|  |        |        |                     |                       |

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

| Are you currently taking any medications? ( <i>Include regularly used over the counter medications</i> ) |  |
|--|--|
| Medication Name  | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

| Do you have any medication allergies? |          |            |                     |
|---------------------------------------|----------|------------|---------------------|
| Medication Name                       | Reaction | Onset Date | Additional Comments |
|                                       |          |            |                     |
|                                       |          |            |                     |
|                                       |          |            |                     |

I choose to decline receipt of my clinical summary after every visit (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_