Healing Hands Chiropractic

Last Name:

1019 N Highland Ave ● Murfreesboro, TN 37130 ● (615)203-3505

Date: _____ Social Security #_____

Name: _____
Last First M.I

Full Address_____

E-mail (please provide for communication purposes) _____

Cell Phone:_____ Home Phone: _____

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor Ch05

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____ Phone _____

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

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

Patient Employer/School _____

Address:_____

Phone: _____ Occupation:_____

Spouse's Name:_____ SS#_____ - _____ - _____ Phone:_____

Birthdate:_____ Spouse's Employer: _____

Emergency Contact:_____ Relationship:_____ Phone_____

**ACCIDENT INFORMATION**: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

***INSURANCE INFORMATION:***

Who is responsible for this account? _____ Relationship to patient:_____

Insurance Co:_____ ID#_____

Subscriber Name _____ Birthdate:_____

**ASSIGNMENT AND RELEASE:** I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Amanda Dee Baes and/or Dr. Katherine Cardel, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of above signature Relationship to Patient

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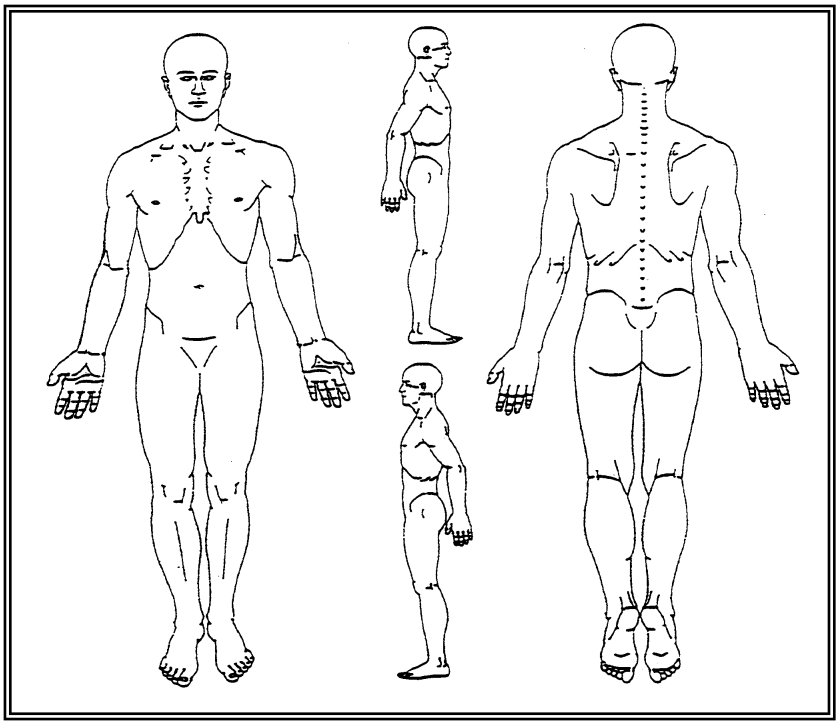
**Please let us know who we can thank for referring you to our office: _____**

**Please indicate the main reason you are seeing us today: _____**

**If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.**

| XXXXXXXXX | / / / / / / / / / / | o o o o o o o o o o | S S S S S | - - - - - - - - |
|---|---|---|---|---|
| **DULL/ACHY** | **SHARP/STABBING** | **NUMBNESS/TINGLING** | **STIFF/TIGHT** | **BURNING** |



**Using the pain scale below, circle the pain level you experience when this problem is at its very worst:**

**0 = No Pain**. No Discomfort
**1 = Minimal Discomfort**. Minor stiffness or tightness.
**2 = Discomfort**. Stiff, tight, sore. Muscle fatigue.
**3 = Minimal Pain**. More than just sore. Uncomfortable.
**4 = Mild Pain**. Noticeable pain but tolerable.
**5 = Moderate Pain**. Aggravating. Still allows movement.
**6 = Strong Pain**. Quite aggravating. Movement slightly limited.
**7 = Very Strong Pain**. Very aggravating. Movement definitely limited.
**8 = Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
**9 = Severe Pain**. Brings tears. Almost impossible to move.
**10 = Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

**Do you have any other health conditions, regardless of whether you think it's related to your spine:**

_____

_____

_____

**Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____**

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## PAST MEDICAL HISTORY

**Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____**

_____

**Please list any surgeries you have had over the course of your life: _____**

_____

## MEDICATIONS & ALLERGIES

**Are you allergic to any medications?** ☐Yes ☐No **If yes, please list: _____**

**List any medications you are taking: _____**

_____

_____

## SOCIAL HISTORY

**Do you have any children?** ☐Yes ☐No If yes, how many? _____

**Do you drink alcohol?** ☐Yes ☐No If yes, how much & how often? _____

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

## PERSONAL HEALTH GOALS

| | | |
|---|---|---|
| ☐Improve Nutrition/Eating Habits | ☐Lower Cholesterol | ☐Get off Medications |
| ☐Weight Loss/Fat Loss | ☐Lower Blood Pressure | ☐Improved Sleep |
| ☐Increase Lean Muscle Mass | ☐Start Exercising | ☐Improved Energy |
| ☐Increase Bone Density | ☐Look Better | ☐Improved Posture |
| ☐Reduce Stress | ☐Feel Better | ☐Improved Outlook/Happiness |

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

**Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____**

**Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No**

**Who is your Family Physician or Primary Doctor that monitors you? _____**

**When was the last time you had blood work done? _____**

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# FAMILY HEALTH HISTORY

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

| | **Father** Age____ | **Mother** Age____ | **Spouse** Age____ | **Brother**(s) Age____ | Age____ | **Sister**(s) Age____ | Age____ | **Children** Age____ | Age____ | Age____ |
|---|---|---|---|---|---|---|---|---|---|---|
| **First Name** | | | | | | | | | | |
| **Condition** | | | | | | | | | | |
| Allergies | | | | | | | | | | |
| Anxiety | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Auto Accidents | | | | | | | | | | |
| Back Pain | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Constipation | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Disc Problems | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Frequent Colds/Flus | | | | | | | | | | |
| Gassy/Bloating | | | | | | | | | | |
| Headache | | | | | | | | | | |
| Heartburn | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| Low Energy | | | | | | | | | | |
| Migraine | | | | | | | | | | |
| Neck Pain | | | | | | | | | | |
| Nervousness | | | | | | | | | | |
| Pinched Nerve | | | | | | | | | | |
| Scoliosis | | | | | | | | | | |
| Sinus Trouble | | | | | | | | | | |
| Sleeping Problems | | | | | | | | | | |
| Other: | | | | | | | | | | |
| Other: | | | | | | | | | | |
| Other: | | | | | | | | | | |

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## Financial Responsibility

**Patient Name_____**

Dear Patient,
Dr. Amanda Dee Baes at Healing Hands Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

I have read and understood all the above information.

_____ _____
Patient Signature Date

## X-Ray Consent

I hereby give my consent to Dr. Amanda Dee Baes, Dr. Katherine Cardel and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____
Patient Signature Date

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**INFORMED CONSENT**

**DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC**

**CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

**ANALYSIS & DIAGNOSIS**

A doctor of chiropractic conducts a clinical analysis to determine if you are a chiropractic candidate. If it is determined you are a chiropractic candidate, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem, in rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not be giving chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. The doctor of chiropractic provides specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

**RESULTS**

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

**TO THE PATIENT**

Please discus any questions or problems with the doctor before signing this statement of policy.
I have read, and understand the foregoing.

_____

Signature