Paramount Health
CHIROPRACTIC

Time _____ RM ___
T 1 2 3

Name _____Date_____ /_____ /_____ Age _____Male / Female

Address_____City_____State_____Zip_____

Phone: Home _____Cell_____ Cell Phone Provider _____Date of Birth_____ / _____ / _____

Email Address_____

Occupation_____ Employer's Name_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you? _____Office Only _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor? _____Medical Doctor?_____ Other_____

Who and When?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	DISC PROBLEM
HEADACHES	THYROID PROBLEMS	MID BACK PAIN	SHOULDER PAIN	INFERTILITY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHRONIC FATIGUE	LUPUS
EAR INFECTIONS	ULCERS	SCIATICA	FIBROMYALGIA	CHRONIC SINUS
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	GASTRIC REFLUX	BLADDER PROBLEMS
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	KNEE PAIN
NECK PAIN	LOW BACK PAIN	ARM PAIN	MENSTRUAL PAIN	EPILEPSY
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	_____
ANXIETY	STOMACH DISORDERS	LEG PAIN	NERVOUSNESS	_____

CIRCLE ANY CONDITION YOU HAVE NOW / HAVE HAD

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

List all surgical operations and years:_____

_____

List all over the counter & prescription medications you are on:_____

_____

_____

When was your last auto accident? _____

Have you had previous chiropractic care? YES / NO

If you have, Dr. & date:_____

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO

If yes, please describe:_____

Other trauma:_____

_____

Social History

1. **Smoking:** ___cigars ____pipe ___cigarettes → How often? ___Daily ____Weekends ___Occassonally ___Never
2. **Exercise:** How often? ____ Daily ____Weekends ____Occassionally ___Never
3. How does your present problem affect the following: **Hobbies --- Recreational Activities --- Exercise**

   _____

4. **What daily activities are being restricted by your current health problems:**

CARRYING/LIFTING GROCERIES	DRIVING	READING/CONCENTRATING	SEXUAL ACTIVITIES
SITTING TO STANDING	PET CARE	SWEEPING/VACUUMING	SLEEP
CLIMBING STAIRS	GARBAGE	DRESSING	STATIC SITTING
EXTENDED COMPUTER USE	LIFTING CHILDREN	SHAVING	STATIC STANDING
YARD WORK	WALKING	BATHING	
LAUNDRY	DISHES		

OTHER: _____

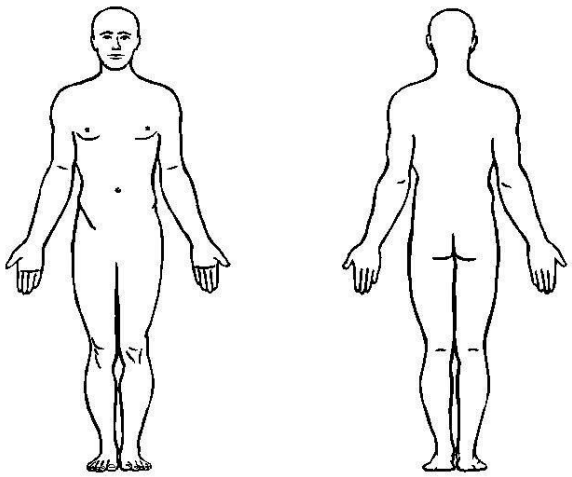
***Please Mark** the areas on the Diagram with the following **letters** to describe your symptoms:

R=Radiating **B=B**urning **D=D**ull **A=A**ching **N=N**umbness

S=Sharp/**S**tabbing **T=T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____



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 YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.
DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.
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 PARAMOUNT HEALTH 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.

Signature: _____ Date:_____ Age:_____

FEMALE PATIENT ONLY: I ensure that I am not pregnant at the time x-rays are taken at Paramount Health Chiropractic.

Signature: _____ Date:_____

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

Sex: M / F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MHA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____

CA Initials: _____

Practice Member Information (Must be completed before services can be rendered)

NAME: _____
First Middle Last

PHONE: Home _____ Cell_____ Work _____

SOCIAL SECURITY NUMBER:_____ MARITAL STATUS:_____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE #:_____

NAME OF PRIMARY INSURANCE CARRIER:_____

NAME OF INSURED: _____ INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

NAME OF SECONDARY INSURANCE CARRIER:_____

NAME OF INSURED: _____ INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

Insurance Policies and Fee Schedule

- **Consultation-** includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and or static palpation, leg check $50-$100
- **Chiropractic Adjustment-** The actual realignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $50 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Paramount Health Chiropractic, LLC. 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. I understand that all professional services rendered are charged to the patient and that 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 the assigned and that Paramount Health Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Print Name: _____ Signature:_____ Date:_____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Print Name: _____ Signature: _____ Date:_____

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 to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Print Name: _____ Signature: _____ Date:_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are done by hand or instrument in this office.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

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

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A CHILD _____

I AUTHORIZE DR. JOHN JONES AND ANY PARAMOUNT HEALTH CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE, AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE 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 PARAMOUNT HEALTH CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____

RELATIONSHIP TO MINOR / CHILD

Family Health History

This form is to assist the doctor by providing past health history information for their review.

Date: _____ Name:_____

CONDITION	SPOUSE	SON	DAUGHTER	FATHER	MOTHER
Arm Pain					
Arthritis					
Asthma					
ADD/ADHD					
Allergies					
Back Trouble					
Bed Wetting					
Cancer					
Carpal Tunnel					
Diabetes					
Digestive Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headaches					
Heartburn					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Disorder					
Migraines					
Neck Pain					
Scoliosis					
Seizures					
Shoulder Pain					
Sinus Trouble					
TMJ					