ADVANTAGE
SPINAL DYNAMICS

Welcome to our Office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don’t hesitate to ask one of our qualified team members.

It is our pleasure to be of service to you.

About the Patient

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (___)_____
Cell Phone (___)_____
Birthdate ___/___/_____ Age _____

Gender □ Male □ Female # of Children____
Employer _____
Work Address _____
_____
Work Phone (___)_____
Type of Work _____
Marital Status □ Married □ Single □ Divorced
□ Separated □ Widowed

SSN _____
Email_____

About the Spouse or Parent

Name _____
(H) _____
(C) _____

Emergency Contact

Name _____
Relationship _____
Work Phone (___)_____
Home Phone (___)_____
Cell Phone (___)_____

Financial Agreement

I, _____, clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

_____ _____
Patient Signature Date Guardian or Spouse Signature Date

Who should receive bills for payment on your account?

□ Patient □ Spouse □ Parent □ Worker's Comp.
□ Medicare □ Personal Health Insurance □ Auto Insurance

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IMPORTANT: All clients are responsible for full payment for the first visit, unless other arrangements have been made in advance.

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

_____ _____
Patient Signature Date Guardian or Spouse Signature Date

Reason for This Visit

Describe the purpose of this visit: _____

Is the purpose of this appointment related to: □ Work □ Sports □ Auto □ Fall □ Chronic □ Other

Explain _____

If work related, have you made a report of your accident to your employer? □ YES □ NO

When did this condition begin? _____ Has this condition □ gotten worse □ stayed constant
□ comes and goes □ improved

Does this condition interfere with □ Work □ Sleep □ Daily Routine □ Other

Explain _____

Has this condition occurred before? □ YES □ NO

Explain _____

Have you seen other doctors for this condition? □ YES □ NO

Explain _____

Doctor's Name(s) _____
Type of Treatment _____
Results _____

Experience with Chiropractic

Who referred you to this office? _____
Have you been adjusted by a chiropractor before? □ YES □ NO
Reason for those visits _____
Doctor's Name _____
Approximate date of last visit _____
Has any *adult* in your family seen a chiropractor? □ YES □ NO If yes, who? _____
Has any *child* in your family seen a chiropractor? □ YES □ NO If yes, who? _____

Current Weight

What is your current weight? _____lbs Do you consider yourself □ Overweight □ Just Right □ Underweight

Do you have questions/concerns regarding your weight? _____
_____

If you could lose weight through proper nutrition would you be interested in learning more for either yourself or someone you care about? □ YES □ NO

Accident Information

Is this visit due to an accident? □ Yes □ No What type? □ Auto □ Work □ Home □ Other
Date of accident:_____ Time of Accident:_____
To whom have you made a report of your accident? □ Auto Insurance □ Employer □ Work Comp
□ None □ Other _____

Attorneys Name: _____Phone: _____

Patient Health History

Who is your primary care physician? (doctor and/ or practice) _____

What treatment have you already received: □ Medications □ Surgery □ Physical Therapy □ Chiropractic □ Other
Explain/Result _____

Name and address or other doctors(s) who have treated your condition: _____
_____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Spinal Exam: _____ MRI/CT-Scan: _____

Medications I Currently Take

□ Nerve Pills
□ Pain Killers (including Aspirin)
□ Muscle Relaxants
□ Blood Pressure Meds
□ Insulin
□ Stimulants
□ Blood Thinners
□ Tranquilizers
□ _____
□ _____

Health Habits

Do you smoke? □ YES □ NO
Do you drink alcohol? □ YES □ NO
Do you drink coffee? □ YES □ NO
Do you exercise regularly? □ YES □ NO
Do you wear □ heel lifts □ sole lifts
□ inner lifts □ arch supports

Health Conditions

Please check each of the diseases or conditions that you have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

□ Severe or Frequent Headaches
□ Sinus Problems
□ Dizziness
□ Loss of Sleep
□ Pain Between the Shoulders
□ Frequent Neck Pain
□ Numbness or Pain in Arms/Legs
□ Lower Back Problems
□ Digestive Problems
□ Ulcers/Colitis
□ Heart Attack/Stroke
□ Thyroid Problems
□ Kidney Problems
□ Hepatitis
□ Cancer
□ Congenital Heart Defect
□ Heart Surgery/Pacemaker
□ High/Low Blood Pressure
□ Difficulty Breathing
□ Asthma
□ Arthritis
□ Scoliosis
□ Alcohol/Drug Abuse
□ Communicable Diseases
□ Osteoporosis
□ Diabetes
□ Tuberculosis
□ Shingles
□ Chemotherapy
□ Anemia
□ Fibromyalgia
□ Psychiatric Problems
□ Other _____

For Women Only:

Are you pregnant? □ YES □ NO How many weeks? _____
Are you nursing? □ YES □ NO
Do you experience painful periods? □ YES □ NO
Do you have irregular cycles? □ YES □ NO

Notice of Privacy Practices & HIPPA Receipt

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

I certify that I have read and understand the above information and have provided all information accurately and to the best of my recollection.

Patient Name: _____ Date: ____/____/_____

Patient Signature: _____ Guardian Signature: _____

Missed Appointment Policy

Here at Spinal Dynamics Chiropractic, we strive to provide you with the utmost professionalism and excellence of service. Our commitment to your health and well-being is something we take very seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need, and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results

- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment please call our office and arrange for a make-up appointment with our Chiropractic Assistants. We would prefer the make-up appointment be within the same week.

In the instance of a missed appointment without notice we reserve the right to charge you a $20.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all of the information written above.

Patient Name: _____ Date: ____/____/_____

Patient Signature: _____ Guardian Signature: _____

INFORMED CONSENT FOR EXAMINATION & TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic (**Dr. Danielle Sartin, Dr. Kurt Slonaker**) and/or his/her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

I understand that as part of my healthcare, Spinal Dynamics Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand that Spinal Dynamics Chiropractic reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I’ve provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Spinal Dynamics Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Patient Name (Printed)	Date Signed
_____	_____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)	Witness to Signature
_____	_____
Doctor of Chiropractic Signature	Date Signed