HONEYBEE CHIROPRACTIC

Adult Patient Intake Form

Today's Date: _____

Name: _____

Date of Birth: _____ Circle One: Male/Female

Address: _____ City: _____ State: _____ Zip :_____

Phone: _____ Email: _____

Occupation: _____ Employer's Name: _____

Circle One: Single / Married / Divorced / Widowed Spouses Name _____

Number of Children: _____ Names and Ages: _____

_____

How did you hear about us? _____

Women Only: Are you Currently Pregnant? YES/NO If so, how many Weeks? _____

Health Concerns:

List Your Health Concerns According to Severity	***Rate of Severity 1= mild 10= unbearable***	***When did this problem Start?***	***Did the problem begin with an injury?***	***Are your symptoms constant or Intermittent?***
1.				
2.				
3.				
4.				
5.				

Have you seen other doctors for these conditions? YES/NO

Chiropractor? _____ Medical Doctor? _____

Other? _____ Who and When? _____

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Circle all Current Problems You Have

Mid Back Pain	*Knee Pain*	*Scoliosis*	*Anxiety*	*Numbness in Extremities*
Low Back Pain	*Hip Pain*	*Joint Pain*	*Migraines*	*Digestive Issues*
Neck Pain	*Shoulder Pain*	*Muscle Pain*	*Headaches*	

Circle Any Condition You Have Now/Have Had

Cancer	*Heart Disease*	*Seizures*	*Scoliosis*
Stroke	*Spinal Surgery*	*Spinal Bone Fracture*	*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 yes, Doctor's name and date: _____

Have you ever been knocked unconciousness? YES/NO Have you ever fractured a bone? YES/NO

If yes, please describe: _____

Any other traumas? _____

Goals

HoneyBee Chiropractic is dedicated to providing the best care possible to help you achieve your goals. With objective goals, we are able to measure progress and results. What would you like to see happen or be able to do with the help of chiropractic care (Circle what is applicable to you?

Less Allergies	*Less Numbness in Extremeties*	*Less Sick Days Immunity*	*Better Digestion*
Better Mobility	*Improved Athletic Performance*	*More Energy*	*Less Anxiety*
Less Pain	*Better Sleeping Patterns*	*Fewer Headaches*	

What are your main goals (examples- pick up kids without pain, increased energy to start exercising, run a marathon, live a healthier lifestyle):

1. _____
2. _____
3. _____

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Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

Patients Name: _____

Patient 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 (HIPPA). I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involvedin that treatment directly and indirectly.
Obtain payment from third-party payers.
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 or disclosed 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.

Patient Signature: _____ Date: _____

HONEYBEE
CHIROPRACTIC

Terms of Acceptance

In order to provide 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:

1. **Chiropractic care 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.**
2. **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.**
3. **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.**
4. **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.**
5. **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.**
6. **Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic.**
7. **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.

Patients Name: _____

Patient Signature: _____ Date: _____