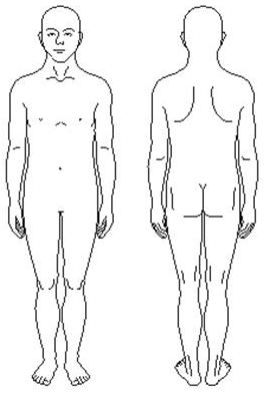
FALLS HEALING ARTS, S.C.

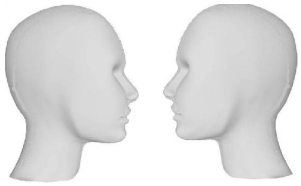
1. PATIENT INFORMATION (OFFICE USE ONLY ACCT# _____) Today's Date _____
Patient Name (First, MI, Last) _____
Address _____ City, State, Zip _____
Phone Home# _____ Work#_____ ext. _____ Cell# _____
Email address: _____ *I would like to receive periodic emails about classes and events Yes/No*
Sex ___ M ___F Age _____ Birthdate _____
___Single ___Married ___Widowed ___Divorced ___Other Height _____ Weight _____
Your Employer _____ ___Full Time ___Part Time
How were you referred to our office? _____

2. INSURANCE INFORMATION
___Cash/Credit ___Medicare ___Medicaid ___Health Insurance ___Worker's compensation ___Personal Injury/Auto
Primary Insurance Carrier Name _____
Do you carry a secondary insurance through a spouse/parent? _____

3. ACCIDENT INFORMATION
Is this condition due to an accident? ___Yes ___No Date _____
Type of accident ___Auto ___Work ___Home ___Other _____
Attorney Name (if applicable) _____

4. PATIENT CONDITION
Reason for visit _____
When did your symptoms appear? _____
What caused this problem? _____
What makes the symptoms worse? _____ What makes the symptoms better? _____
Shade and code areas to indicate location of pain or discomfort: (use codes below)





Right View Left View

Numbness	- - - - -
Pins and Needles	+++++
Burning	XXXX
Dull Ache	ooooo
Stabbing Pain	/ / / / /

Rate the severity of your pain on a scale from 1 (minimal) to 10 (severe) _____

How often do you have this pain? _____

Is it constant or does it come and go? _____
Does it interfere with your ___work ___sleep ___daily routine ___recreation
Activities or movements that are painful to perform ___sitting ___standing ___walking ___bending

___lying down other_____

IN CASE OF EMERGENCY, CONTACT _____

Phone # _____ Relationship _____

Blood Pressure _____ ***Pulse*** _____ ***Height***_____ ***Weight*** _____
_____ Enter Vitals in SOAP note _____Scan in pt file

5. HEALTH HISTORY

What treatment have you already received for your condition? ___medications ___surgery ___physical therapy ___chiropractic ___none other _____

Name and address of other doctor(s) who have treated you for your condition? _____

_____

Date of last:

Physical Exam _____ Spinal X-Ray_____ Spinal Exam _____ Chest x-ray _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____ Blood Test _____ Urine test _____

Place an X next to "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	___yes ___no	Glaucoma	___yes ___no	Pinched Nerve	___yes___no
Alcoholism	___yes ___no	Gonorrhea	___yes ___no	Pneumonia	___yes___no
Allergy shots	___yes ___no	Goiter	___yes ___no	Polio	___yes___no
Anemia	___yes ___no	Gout	___yes ___no	Prostate Problems	___yes___no
Anorexia	___yes ___no	Heart Disease	___yes ___no	Prosthesis	___yes___no
Appendicitis	___yes ___no	Hepatitis	___yes ___no	Psychiatric Care	___yes___no
Arthritis	___yes ___no	Hernia	___yes ___no	Rheumatoid Arthritis	___yes___no
Asthma	___yes ___no	Herniated Disc	___yes ___no	Rheumatic Fever	___yes___no
Bleeding Disorders	___yes ___no	Herpes	___yes ___no	Scarlet Fever	___yes___no
Breast Lump	___yes ___no	High Cholesterol	___yes ___no	STD's	___yes___no
Bronchitis	___yes ___no	Kidney Disease	___yes ___no	Stroke	___yes___no
Bulimia	___yes ___no	Liver Disease	___yes ___no	Suicide Attempt	___yes___no
Cancer	___yes ___no	Measles	___yes ___no	Thyroid Problems	___yes___no
Cataracts	___yes ___no	Migraine	___yes ___no	Tonsillitis	___yes___no
Chemical Dependency	___yes ___no	Miscarriage	___yes ___no	Tuberculosis	___yes___no
Chicken Pox	___yes ___no	Mononucleosis	___yes ___no	Tumors, Growths	___yes___no
Diabetes	___yes ___no	Multiple Sclerosis	___yes ___no	Typhoid Fever	___yes___no
Emphysema	___yes ___no	Mumps	___yes ___no	Ulcers	___yes___no
Epilepsy	___yes ___no	Osteoporosis	___yes ___no	Vaginal Infections	___yes___no
Fracture	___yes ___no	Pacemaker	___yes ___no	Whooping Cough	___yes___no
Hand Dominance	_____R____L	Parkinson's	___yes ___no	Other: _____	

EXERCISE	WORK ACTIVITY	HABITS
___None	___Sitting	___Smoking Packs/Day _____
___Moderate	___Standing	___Alcohol Drinks/Wk _____
___Daily	___Light Labor	___Coffee/Caffeine Cups/Day ____
___Heavy	___Heavy Labor	___High Stress Level Reason _____
Are You Pregnant? ___Yes ___No	Due Date: _____	

6. INJURIES/SURGERIES YOU HAVE HAD

	Description	**Date**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

7. MEDICATIONS / ALLERGIES / VITAMINS / HERBS / MINERALS

_____

_____

_____

Falls Healing Arts S.C.

Consent to Treat:

The primary treatment used by Doctors of Chiropractic is the spinal adjustment. We will primarily use that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. Additionally, other treatments may be used to help you, and will be explained to you at the time the Doctor decides to utilize these techniques or treatments.

The side effects associated with a chiropractic adjustment are extremely rare. Initially, a small amount of soreness may be expected in certain cases, but this can be discussed with the Doctor. Any other concerns or questions may also be discussed with the Doctor.

By signing below you state that you are wiling to undergo a chiropractic examination, x-rays of the spine or the area(s) involved (if indicated), and chiropractic treatment as may be outlined by the Doctor after the examination has been done.

In addition, it is important to understand that health and accident insurance policies are arrangements between you and your insurance carrier. As a courtesy to you, our office will bill your insurance company under normal circumstances and will complete any necessary forms to assist you in collection of payment from your insurance company assuming you have assigned benefits to be paid directly to our office. However, please understand that you are personally responsible for any and all charges regardless if your insurance company pays or not.

Signature: _____ Date: _____

Consent to treat minor child: _____

Relation: _____

Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPPA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the front desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the "NOTICE OR PRIVACY PRACTICES" binder in reception or ask for a copy at the front desk.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, courtesy call, balances due, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving messages from the automated outreach and messaging system, when necessary.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Name (Printed Please)	Signature	Date