

Braile Chiropractic



Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your God given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions, please feel free to ask us.

To initiate care at our facility, there are **two required visits**, your Initial Examination visit and your Principled Doctor's Report. If you cannot attend either of these two subsequent visits, the negative impact on your care will be profound, and we cannot in good conscience begin your care.

1. **Your Initial Examination:** In your first visit, you will have an initial consultation with the doctor. This is usually followed by a chiropractic examination including nerve systems scans and spinal x-rays if warranted and appropriate.
2. **Your Principled Doctor's Report (X-ray Report):** This will be your longest visit at our clinic lasting approximately **90 minutes**. It will cover a large amount of information and include a detailed personalized individual report of findings with recommendations for your care. Any x-rays taken will be individually reviewed at this time. We highly recommend that spouses and adult family members attend this visit with you so that they can hear first-hand about chiropractic. We love children, however, young children should not attend this visit as the material may be too advanced, and children will find it difficult to stay attentive for that amount of time without creating a distraction. Due to the time needed for the Principled Doctor's Report, we set aside special hours and days for this visit. Check with our receptionist for the available times.

I consent to initiate care in the form of an examination, nerve scans, and, if needed, x-rays at Braile Chiropractic. I understand that I am under no obligation to either receive any further care unless I agree to such care at my Principled Doctor's Report.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA) and 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 physician 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 that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name _____ Date _____

Sign your name _____

Braille Chiropractic



Print Name _____ Email _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Do you have insurance that you believe may cover part of your chiropractic care?

Please Check Yes No Name or type of insurance: _____

Health History

Give reason for seeking chiropractic care: _____

Additional details about this issue: _____

Describe any other health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No If Yes, explain conditions being treated for:

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History

Your Occupation _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History

Have you ever been to a Chiropractor before? Yes No If yes, Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes No If yes why? _____

Rate Your Overall Health

Our goal is to help you achieve and maintain optimal health. To better help you with this we need to understand how you view your overall health. Please **circle** what you consider to be your current level of health.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Referrals

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know who referred you, **or** where you heard about our clinic? _____

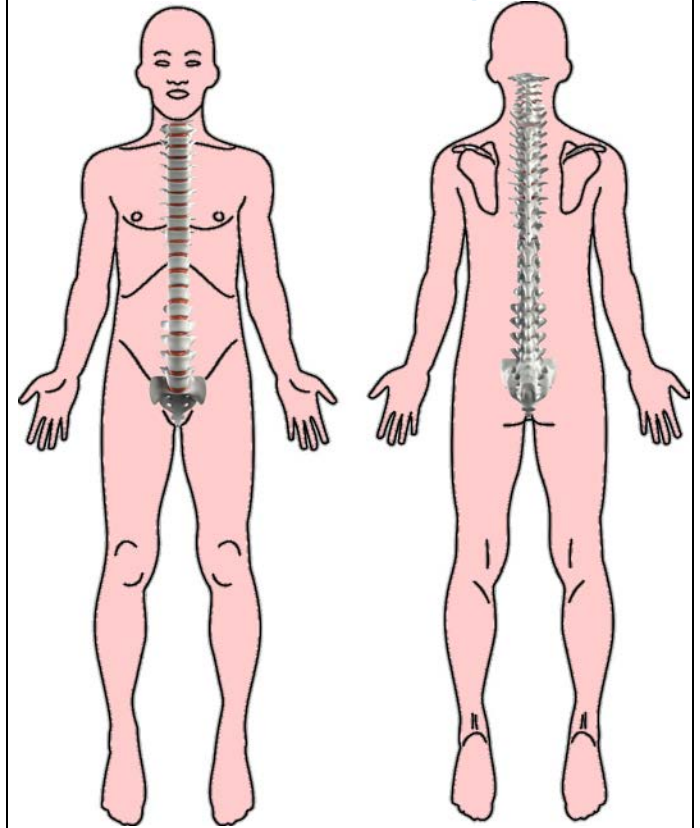
FEMALES Please Check One Is there a possibility of you being pregnant? Yes No

Please Fill in Below

If you currently or recently have suffered from the following, *please check if YES* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg / Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Female Issues	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
Write in:		

Circle the areas where you have any problems. Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your care.

Your Signature Below Please

Date: _____