Consent to Initiate Care

Braile Chiropractic

At our office, we have one simple goal. We want to change your life by rendering the highest quality chiropractic care. 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.

When starting care at our facility, there typically ***two visits*** you will be scheduled for. Your **Initial Examination** visit and your **Report of Findings with First Adjustment**.

1. **Initial Examination:** On 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. This visit is approximately 30 minutes long.
2. **Report of Findings:** This will be your longest visit at our clinic lasting approximately **60 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 X-ray Report, we set aside special hours and days for this visit. Check at the front desk 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_____

Braile Chiropractic

Adult Health History Form

Please print clearly and fill in completely

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? _____

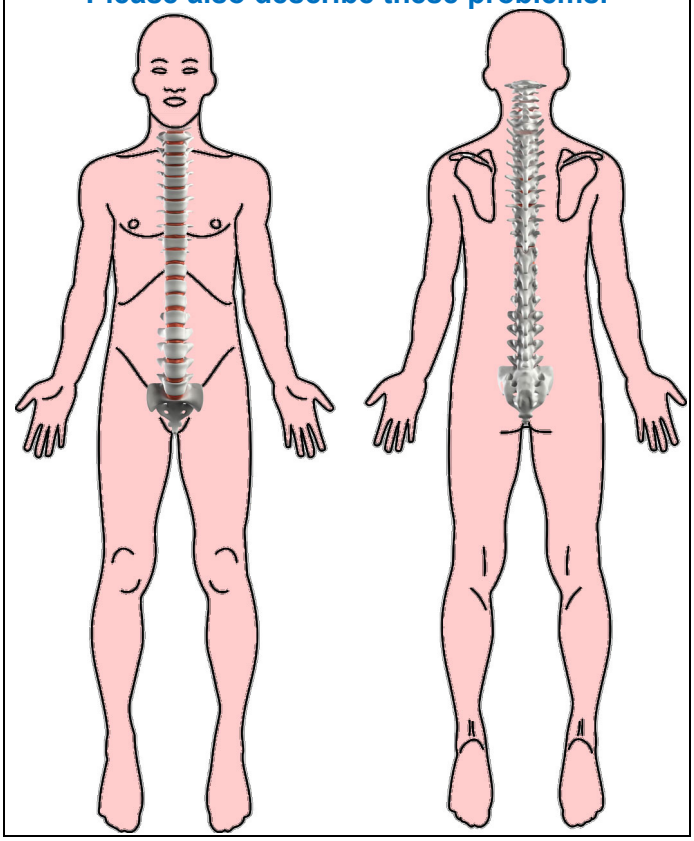
FEMALES ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes** ❑ **No** ❑

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	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg / Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Joint Pain / Swelling	❑	❑
Numbness	❑	❑
Frequent Colds	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Anxiety / Depression	❑	❑
Sleep Disorders	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Female Issues	❑	❑
Cancer	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Osteoporosis	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other: Write in:	❑	❑

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



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

Your Signature Below Please

Date: _____