Healing Lakes Chiropractic

Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Gender:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone Number:** _____

Email: _____

How did you hear about us? _____

What is your occupation? _____

Have you ever had Chiropractic care before? Y / N
If so, when was your last adjustment? _____

Have you ever been in an accident? Y / N
If so, what type of accident and when? _____

Have you ever had any surgeries? Y / N
If so, what type and when? _____

Have you ever had cancer? Y / N
If so, what type and when? _____

Are you taking any medications? Y / N
If so, what type and what is it for? _____

Are you taking any supplements? Y / N
If so, what type and what are they for? _____

What is your primary complaint today? _____

How long have you had this problem? _____

On a scale of 1 to 10, 10 being the worst, what is your pain level? 1 2 3 4 5 6 7 8 9 10

Consent

By signing below, I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, and, if necessary, I will be referred out for diagnostic x-rays. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____

Guardian Signature, if minor: _____

Cancelation and No Show Policy

A $55 fee will be charged to your account for any visits that were not canceled prior to three hours before the appointment.

Please **initial** that you have read and understand this policy: _____

Authorization Form

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

- ☐ **This authorization will expire upon my request.**
- ☐ **Or by this date _____**

Persons authorized to receive the information:

Name:_____ Relationship to patient: _____

DOB:_____ Phone number: _____

Name:_____ Relationship to patient: _____

DOB:_____ Phone number: _____

Name:_____ Relationship to patient: _____

DOB:_____ Phone number: _____

Name:_____ Relationship to patient: _____

DOB:_____ Phone number: _____

The information will be used/disclosed for the following purposes:

- ☐ Insurance
- ☐ Scheduling/moving/confirming appointments
- ☐ Not applicable

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that the office will not condition treatment, payment, or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the office in writing.

Signature:_____ Printed Name: _____