HEALING HANDS CHIROPRACTIC, LLC

3 Hall Ave ♦Wallingford CT 06492 ♦ 203-626-9994

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Full Name _____ Date_____

Mailing Address_____
Street City State Zip

Home Phone ( )_____ Mobile Phone_____Work Phone ( )_____

Social Security #_____ Driver's License #_____

Email address_____

Marital Status: M S W D Age_____ Birth Date_____ No. of children_____

Pregnant?_____ Height _____ Weight_____ Occupation_____

Occupation_____Employer's Name and Address _____

Spouse Occupation/Employer_____

Name of person responsible for account_____

Do you have insurance that covers Chiropractic care? ❑ Yes ❑ No Do you have Medicare Coverage? ❑ Yes ❑ No

Name of Insurance Company_____ Group/Policy #_____

Address_____ Phone_____

Whom may we thank for referring you?_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Malton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Reponsible Party Signature Relationship (Self/parent/spouse) Date

I. HEALTH CONCERNS

(Please list your health concerns according to their severity)

	Rate of Severity 1=Mild 10=Worst	Date started, for how long?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit? _____

I do (do not) have a family history of this or similar symptoms. (Please explain):_____

Is this condition interfering with your: Work_____ Sleep_____ Daily routine_____ Sports/exercise_____ Other_____

Which activities aggravate your condition?_____

Other Doctors seen for this condition:

"Limited Scope" Chiropractor (Focuses mainly on neck and back pain)_____

Wellness Chiropractor (Focuses on health and well-being as well as underlying cause of pain and health concerns)_____

Naturopath_____ Homeopath_____ Medical_____ Dentist_____ Other_____

Name/Address:_____

When? _____ What did they say was wrong? _____

What did they do?_____ Did it help?_____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc…? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc…) If so, what?

_____

Are you unable to do certain activities that you would like to do because of your health? (i.e. sports, walk, pick up grandchildren, etc…) If so, what?_____

Have you had any surgery? (please include all surgery)

1. Type_____ When_____ Doctor_____
2. Type_____ When_____ Doctor_____
3. Type_____ When_____ Doctor_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type_____ When_____ Hospitalized: ____Yes ____No

2. Type_____ When_____ Hospitalized: ____Yes ____No

3. Type_____ When_____ Hospitalized: ____Yes ____No

Have you ever had X -rays taken? _____ When?_____ Where?_____

Area of the body:_____

Do you wear orthotics or heel lifts? Yes_____ No_____

II. CURRENT MEDICINE(S*)*

Please list ALL drugs you currently take or have taken in the past 6 months:

Name_____ Dosage_____ For what?_____
Name_____ Dosage_____ For what?_____
Name_____ Dosage_____ For what?_____
Name_____ Dosage_____ For what?_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take:

Name_____ For what?_____
Name_____ For what?_____
Name_____ For what?_____
Name_____ For what?_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being and would you be willing to make dietary changes if indicated? Yes_____ No_____ Maybe_____

Would you take food supplements if indicated? Yes_____ No_____ Maybe_____

Name: Date:

III. HEALTH HISTORY

Mark the following conditions you may have had or have now ("-" have had, "+" have now)

___Allergy	___Diarrhea	___Measles	___Rheumatic Fever	___Alcoholism	___Eczema
___Miscarriage	___Stroke	___Anemia	___Multiple Sclerosis	___HIV (AIDS)	___Gout
___Arteriosclerosis	___Emphysema	___Mumps	___Sinus Problems	___Arthritis	___Neuritis
___High Blood Pressure	___Asthma	___Nervousness	___Thryroid Problems	___Ulcers	___Cancer
___Heart Disease	___Depression	___Convulsions	___Venereal Disease	___Malaria	___Pleurisy
___Constipation	___Pneumonia	___Cold Sores	___Whooping Cough	___Polio	___Neck Pain
___Gall Bladder Problems	___Migraines	___Headaches	___Menstrual Cramps	___Back Pain	___Epilepsy
___Irregular Periods	___ Heart Attack	___Tuberculosis	___Low Blood Sugar	___ Diabetes	___Ringing in Ears

___Other: (Please Explain) _____

IV. STRESSES

Please list your top three stressors in each area (remember stress is cumulative throughout our lives)

PHYSICAL: (Ex. Birth trauma, falls, injuries, sports, poor posture, computer work, hard labor, etc…)

1. _____ 2. _____ 3. _____

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

EMOTIONAL/MENTAL: (Ex. Job/school stress, move, loss of loved one, abuse, divorce, financial, etc…)

1._____ 2. _____ 3. _____

How do you grade you emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

CHEMICAL: (Ex. Fast food, artificial sweeteners, sugar, soda/pop, refined foods, alcohol, nicotine, household or comercial cleaners, pollution, pesticides, prescription drugs, antibiotics, over-the-counter drugs, etc…)

1._____ 2. _____ 3. _____

How do you grade your chemical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

V. CONCLUSION

Is there anything else which may help to better understand you, which has not been discussed?

_____

Why are you here at this point in time?_____

Print Patient Name_____ Date_____

Signature_____
(Patient/Parent/Guardian)

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:

Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**

About ___ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____.

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

❑ **No** ❑ **Yes** _____

Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**

Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing an increased level of stress? ❑ **No** ❑ **Yes**

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.
Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.
Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ _____
(signature) (date)

Healing Hands Chiropractic LLC

HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name_____

Person/s you are ***releasing*** information to: _____

_____

***Please choose one** _____ Any information _____ Billing information only

Person/s ***not to release*** information to: _____

Patient signature
OR
Guardian signature_____

Print Name if Guardian_____ Date_____

A copy of complete HIPPA policy is available by request.

____Refused to sign_____

Treatment Disclaimer

Is your treatment for any of the following? Please circle **YES/NO**

Worker's Comp **Yes** **No**

Personal Injury with Attorney** **Yes** **No**

Auto accident ** **Yes** **No**

Auto Accident on Company time **Yes** **No**

Health & Wellness **Yes** **No**

Other ie: slip/fall **Yes** **No** (If **Yes**, please explain)

_____

I understand that if at any time during my care at Healing Hands Chiropractic, LLC it is deemed as Worker's Compensation that HHC does not participate in Workers Comp. If my care is found to be Workers Comp. HHC will provide notes at an additional fee, but will not provide reports, scans etc.

Please note, If this is a **Personal Injury or **Auto** case we require a Letter of Protection, Letter of Representation, and Medical Authorization **PRIOR TO CARE BEING GIVEN.**

_____ **Date**_____

Patient Signature

EZ-Pay Signature-On-File Authorization

I, _____, hereby authorize **Healing Hands Chiropractic, LLC** to initiate payments from my credit or bank account with the financial institution identified by me on this form for payment of services and/or products provided by **Healing Hands Chiropractic, LLC** not to exceed $_____ per transaction.

_____ (initial) I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Healing Hands Chiropractic, LLC** in writing of any changes in my account information or termination of this authorization at least 15 days prior to any further charges to my credit card or bank account. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Notice to cancel can be given by either mailing to: 3 Hall Ave Wallingford, CT 06492 **or** faxing to: **203-284-3677**

Signature: _____ Date: _____

CREDIT CARD *(last 4 digits)* ___ ___ ___ ___ (Circle One) VI, MC, AM, DI

Card Holder's Printed Name: _____

Signature: _____ Date: _____

ACH BANK ACCOUNT *(last 4 digits)* ___ ___ ___ ___

Bank Name: _____

Bank Account Holder's Name: _____

If ACH Transactions are rejected for Non Sufficient Funds (NSF) I understand that **Healing Hands Chiropractic, LLC** may at its discretion attempt to process the charge again within 30 days, and agree to any additional **$25.00** charges for each attempt returned NSF which will be initiated as a separate transaction.

Signature: _____ Date: _____

Billing Address Associated with Credit Card or Bank Account

Billing Address:_____ Phone: _____

City, State, Zip: _____