Personal and Family Health History

Name _____
Date _____
Address _____
City _____ State ____ Zip _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)

Referred By _____
Social Security # _____
Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____

Number of Children and Ages

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Previous Chiropractic Care?

Yes___ No___ Reason _____
Yes___ No___ Reason _____
Yes___ No___ Reason _____
Yes___ No___ Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply	***Patient***	***Spouse***	***Child#1***	***Child#2***	***Child #3***	***Chiropractor's Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____

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Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
Major _____
Pain or Problem started on_____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you been under drug and medical care? _____
What medications are you taking? _____
How Long? _____ Have you had surgery? _____ What? _____ When?_____
What side effects have you experienced from the drugs and surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.
❒ Still living ❒ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❒ Feel better quickly
❒ Have a healthier spine and nervous system
❒ Live a healthier lifestyle

_____ _____
Signature Date

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Name_____ Date_____

FABQ

Here are some of the things which other patients have told us about their pain. For each statement, please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

		Completely disagree			Unsure			Completely agree
1.	My pain was caused by physical activity.	0	1	2	3	4	5	6
2.	Physical activity makes my pain worse.	0	1	2	3	4	5	6
3.	Physical activity might harm my back.	0	1	2	3	4	5	6
4.	I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
5.	I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain.

		Completely disagree			Unsure			Completely agree
6.	My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
7.	My work aggravated my pain.	0	1	2	3	4	5	6
8.	I have a claim for compensation for my pain.	0	1	2	3	4	5	6
9.	My work is too heavy for me.	0	1	2	3	4	5	6
10.	My work makes or would make my pain worse.	0	1	2	3	4	5	6
11.	My work might harm my back.	0	1	2	3	4	5	6
12.	I should not do my normal work with my present pain.	0	1	2	3	4	5	6
13.	I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14.	I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15.	I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16.	I do not think that I will ever be able to go back to work.	0	1	2	3	4	5	6

1, 8, 13, 14, 16

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 towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An 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: A 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 to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area.

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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

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

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

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HIPAA PRIVACY ACKNOWLEDGMENT

Plasker Family & Performance Chiropractic is committed to protecting the privacy and confidentiality of your personal and health information. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), your protected health information may be used and disclosed for purposes of treatment, payment, and healthcare operations, as permitted or required by law.

By signing below, I acknowledge that I have been provided access to Plasker Family & Performance Chiropractic's Notice of Privacy Practices, which explains how my health information may be used and disclosed and describes my rights regarding my protected health information.

I understand that I may request restrictions on certain uses or disclosures of my health information; however, the practice may not be required to agree to all requested restrictions. I also understand that I may request a copy of the Notice of Privacy Practices at any time.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

Relationship to Patient (if applicable): _____

ChiroHealthUSA
The Network That Works for Chiropractic!

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR ENROLLMENT AND MEMBERSHIP IN THE CHIROHEALTHUSA NETWORK

I,_____, authorize my provider,_____, to use and disclose my health information (including my name, phone number, address, email address, date of birth, gender, dependents name, name of my provider, and payment information) to ChiroHealthUSA for purposes of enrolling me in the ChiroHealthUSA network, and to send me marketing materials and other communications related to my ChiroHealthUSA network membership. I understand that my provider will not receive direct or indirect remuneration from ChiroHealthUSA in connection with this use and disclosure of my health information.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") and various state laws govern the terms of this Authorization. I understand this Authorization is limited to only the health information described above, and does not apply to sensitive categories of information (such as psychotherapy notes, genetic, mental health, substance abuse, or HIV/AIDS information).

I understand that I may revoke this Authorization at any time by contacting my provider and/or ChiroHealthUSA in writing at 250 Katherine Dr., Flowood, MS 39232, 888-719-9990. My revocation will be effective upon my provider and/or ChiroHealthUSA's receipt of such revocation, but will not be effective to the extent that they have already acted in reliance upon my prior Authorization.

I understand that my provider may not condition treatment or payment, or eligibility for benefits or enrollment in a health plan, on my signing of this Authorization. I understand that my health information disclosed pursuant to this Authorization may be further used and disclosed by ChiroHealthUSA to communicate with me regarding my ChiroHealthUSA membership, and no longer protected by HIPAA. I understand that I have a right to receive a copy of this Authorization.

This Authorization shall expire in accordance with the below, unless earlier revoked by me by notifying my provider and/or ChiroHealthUSA using the contact information and in the manner described above (check the applicable box):

- ☐ **Maryland**: One year from the date of signing this authorization
- ☐ **Maine**: 30 months from the date of signing this authorization
- ☐ **California**: On the_____day of_____, _____
- ☐ **All other states**: When my membership expires

_____ _____
Signature of Patient or Personal Representative Date of Signature

_____ _____
Relationship to Patient Patient Address

Office Fee Schedule and Financial Policy

Service	Regular Fees	Procedure Codes	CHUSA Fees
Consultation	**$95** ***Waived if you proceed with an exam**		**$95** ***Waived if you proceed with an exam**
NP Exam Basic NP Exam Intermediate NP Exam Comprehensive	**$150** **$225** **$340**	**99202** **99203** **99204**	**$125**
Established Patient Re-Exam	**$115**	**99212**	**$105**
Adjustment Instrument Adjusting Radiologic Exam	**1-2 regions $60** **3-4 regions $80** **5+ regions $105** **ArthroStim $55** **$200** **Per View $40**	**98940** **98941** **98942** **97140**	**$55** ***Includes manual therapy if performed** **$150** **Per View $30**
Student/Children Adjustment (17 and under)	**Regular fees as stated above**		**CHUSA only $35**

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Adjustment Plan in advance. These plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition, Lifestyle and Performance Care Options. Details of these plans will be discussed with you during your Chiropractic Report.

☐ **Insurance and Health Savings Account**

If you have insurance coverage that covers chiropractic, our office will provide you with receipts for you to submit to your insurance company and they should reimburse you directly based on your policy's out-of-network benefits. Services will be listed at the regular fee as stated above. We can also provide receipts for your submission to personal and company Health Savings Accounts, which qualify for CHUSA fees. These receipts will be emailed to you monthly.

☐ **CHUSA Network Members – Discount Fee Schedule Above**

We are a participating provider of ChiroHealth USA, CHUSA, a third-party membership program that gives you access to the **DISCOUNTED FEE SCHEDULE** listed above. The CHUSA family fee is only $49 per year and we can register you in our office at any time. Most of our patients CHUSA to be the most cost-effective way to participate in their chiropractic care, even if they have partial coverage through traditional insurance.

I, (name) _____ have read the above policies and checked the one that applies to me.

Patient signature_____Date_____/_____/_____