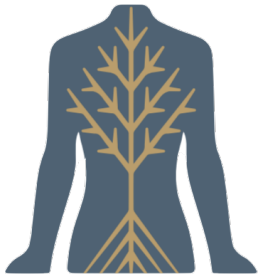
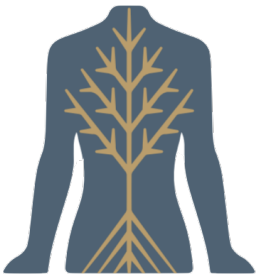


Welcome to the Healing Ground!

It's a pleasure to meet you!

Please completely fill out all applicable information:



Patient's Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ Gender: Male Female Non-binary

Cell Phone #: _____ Alt. #: _____

Email: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

How did you hear about us?

Friend or Family _____

Internet Booth / Ad Other _____

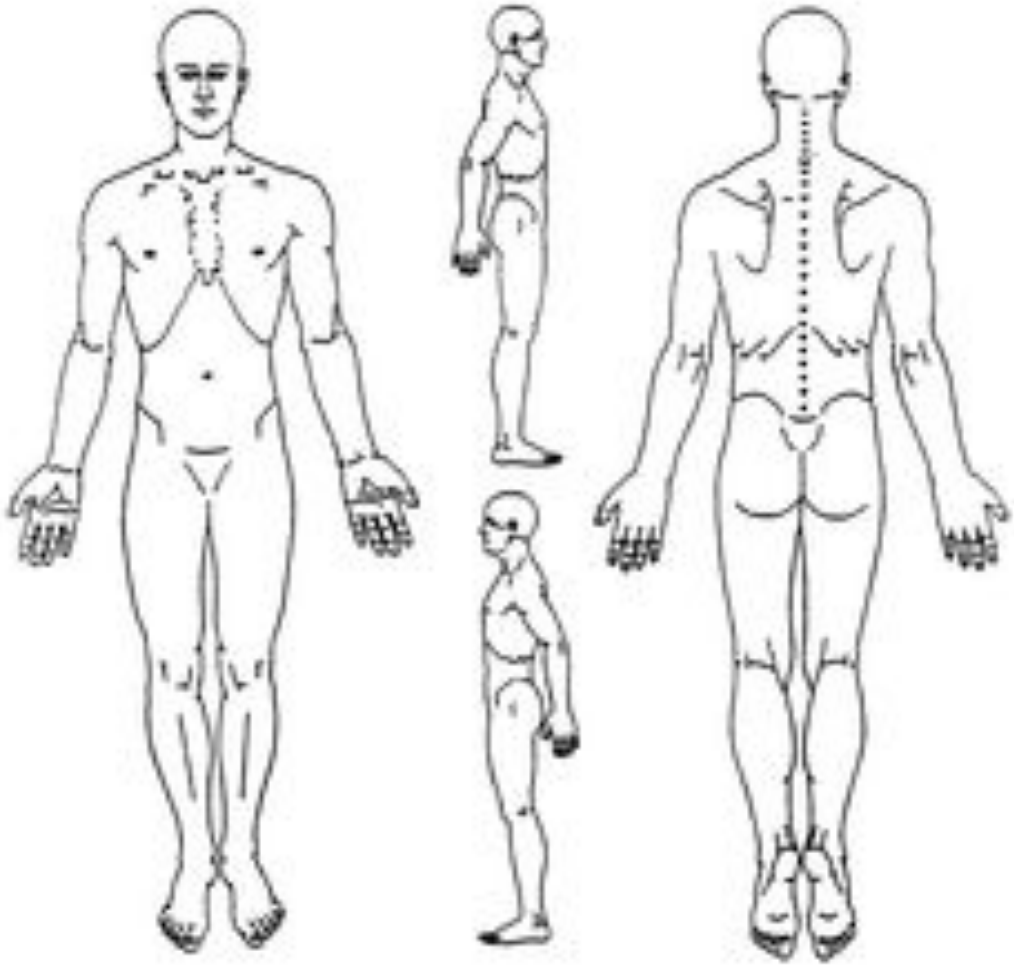
Note: Although Healing Ground Chiropractic Care will give you all information you need to be reimbursed by your insurance company if you have chiropractic benefits, the ultimate financial responsibility remains with you, the patient. By signing this, you are consenting to receive chiropractic care at our low cash rate.

Patient Signature: _____ Date: _____

Parent/Guardian signature if patient is under 18.

Parent/Guardian Name: _____ ***(if under 18)***

To help you feel better faster, we treat the whole body every visit. <u>In addition to your Primary Complaint</u>, please circle any other Areas of Concern.



Patient Signature: _____ Date: _____

Primary Complaint: _____

When did this begin? _____

Any Other Concerns: _____

Has this Occurred before? Yes No

Please explain: _____

Symptoms are worse (please circle): Morning Evening Same

After activity (explain): _____

Describe the quality of your symptoms (circle all that apply):

Deep Dull Sharp Stabbing Electrical Shooting Achy

Burning Throbbing Cramping Tingling Other:_____

Severity of current symptoms:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

(No Pain) *(Emergency Room Pain)*

Frequency of current symptoms (please circle)**:** Constant Comes-and-Goes

Percentage of day when symptoms are felt: (0-100%): _____

What Makes your symptoms <u>better</u>?: _____

_____

What Makes your symptoms <u>worse</u>?: _____

_____

Does your discomfort travel down your arms or legs? Yes No

Please explain: _____

Have you experienced a loss of sleep due to your complaint? Yes No

Have you experienced any unexplained weight loss? Yes No

Does this problem interfere with your life or work? Yes No

Occupation: _____ **Hobbies:** _____

Have you received any other treatment for this condition? Yes No

Please explain: _____

Have you received chiropractic care before? Yes No

If yes, date of your last adjustment: _____

What Medications or supplements are you currently taking?

_____

_____

How many glasses of water do you typically drink in a day? _____

How many meals per week do you prepare at home? _____

What is a typical meal? _____

How many hours of sleep do you get per night? _____

Do you wake rested? _____

Has any member of your family (parents, grandparents, siblings) been diagnosed or treated for Cancer, Heart Disease, Diabetes, or Neurological Condition? Yes No

Please explain: _____

_____

Please circle all that apply to your current or past Personal Health History ***(mark current with C, past with P):***

Cardiovascular	**Gastrointestinal**	**Neurological**	**General**
Heart trouble Chest Pain Heart Murmur Palpitations Varicose Veins Calf Pain with Walking	Nausea Diarrhea Constipation Abdominal pain Flatulence Change in Appetite Frequent Urgency to Urinate	Light headed/dizzy Convulsions/ Seizures Numbness/Tingling Tremors History of Head Injury Memory loss Fainting Poor Balance/Coordination	Weight Change Loss of Appetite Insomnia Fever Anemia Frequent Headaches Allergies Leaky Bladder Prolapse (bladder/uterus /colon)
Eyes	**Respiratory**	**Ear/Nose/Throat**	**Mental/Emotional**
Eye Disease Glasses or Contacts Blurred or Double Vision Vision Loss	Shortness of Breath Chronic Cough Asthma	Hearing Loss Ringing in the ears Sinus Problems Nose Bleeds	Depression Anxiety Fatigue
Musculoskeletal	**Endocrine**	**Skin**	**Gynecological**
Joint pain Joint Swelling Muscle Weakness Back Pain Neck Pain	Excessive thirst Heat or Cold Intolerance Sensitivity to light Hot or Cold hands/feet	Rash Itching Dry Skin Easy Bruising Redness/ Discoloration	Currently Pregnant Y/N Previous Pregnancies: _____ Delivery method: _____ Age of child: _____ Contraception used: _____ Post Menopausal: Yes No Onset: _____

Patient Signature: _____ Date: _____

Health History

Motor Vehicle Accident:

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Surgery:

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Fractures / Dislocations:

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Date: _____ Details:_____

_____

Illness:

Date: _____ Details:_____

_____

Date: _____ Details:_____

Other:

Patient Signature: _____ **Date:** _____

Nijmegen Questionnaire

Please circle the number in the column that best represents what you have felt recently.

	Never	Rarely	Sometimes	Often	Very Often
Chest pain	0	1	2	3	4
Feeling tense	0	1	2	3	4
Blurred vision	0	1	2	3	4
Dizzy spells	0	1	2	3	4
Feeling confused	0	1	2	3	4
Faster or deeper breathing	0	1	2	3	4
Short of breath	0	1	2	3	4
Tight feelings in chest	0	1	2	3	4
Bloated feeling in stomach	0	1	2	3	4
Tingling fingers	0	1	2	3	4
Unable to breathe deeply	0	1	2	3	4
Stiff fingers or arms	0	1	2	3	4
Tight feelings round mouth	0	1	2	3	4
Cold hands or feet	0	1	2	3	4
Palpitations	0	1	2	3	4
Feeling of anxiety	0	1	2	3	4
Column Totals	**0**				

Grand Total	

Informed Consent to Receive Care

PATIENT NAME: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis, examination and treatment the Healing Ground Chiropractic Clinic may include, but is not limited to: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological exam, muscle strength testing, postural analysis testing, and hot/cold therapy, soft tissue manipulation, functional taping.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest, Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, Surgery. If you chose to use the noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Carly Hudson, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Signature: _____ **Date:** _____

Parent/Guardian signature if patient is under 18.

Doctor Signature: _____ Date: _____

HIPAA Policy

I hereby acknowledge that upon request, I will receive a copy of HIPAA privacy forms.

Patient Signature: _____ Date: _____

No Show and Cancellation Policy

In order to be respectful of the health needs of other patients, please be courteous and call the Healing Ground Chiropractic Care if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, **we require that you call at least 24 hours in advance**. We appreciate your accommodation as your early cancellation will give another person the possibility to have access to timely care.

If an appointment is not cancelled **at least 24 hours in advance** you will be charged a **sixty-five dollar ($65) fee**; this will not be covered by your insurance company.

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 8 minutes past their scheduled time, we will have to reschedule the appointment as this does not provide adequate time for appropriate patient assessment and treatment.

Signing this states that you have read, and agree to, The Healing Ground Chiropractic Care's no show and late cancellation policy. If you would like a copy of this policy, just ask and one will be provided for you.

Patient Signature: _____ Date: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment or to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ **(Patient Initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is:_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is:_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ **(Patient Initials)** I consent to photographs, videotapes, digital or audio recordings, and /or images of me being recorded for the practice's health care operations purposes (e.g., recording a demonstration of home care exercises). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Patient Signature: _____ **Date:** _____