Turning Leaf Chiropractic

Health Profile

Personal Information

Name: ____ Date: ________________________

Preferred Name: ___________________________ DOB: ______________ Gender: ______________

Address: ____________________________________ City/State/Zip:_________________________

Email: _________________________ Cell Phone: ______________ Other Phone:________________

If under 18 years old:

Parent/Guardian Name: _____________________________ *Parent/Guardian Phone:* ______________

Marital Status: Single/Married/Partner/Divorced/Widowed Spouse/Partner Name: __________________

Who Lives In Your Household? Names & Relationship: _____________________________________

Employer/Occupation: _________________________________ Work City: _____________________

Are you a student? If yes, where? ____

Are you receiving care from any other health professional? Yes No

If yes, please name them and their specialty: ____

Whom may we thank for your referral? ____

Chiropractic History

Have you been to a chiropractor before? Yes No If yes, provider's name? ________________________

If yes, what was the reason for those visits? ____

How often, how many times, for what period?____

Date of last visit? ______________________

Has any other adult in your family seen a chiropractor? Yes No

Has any child in your family seen a chiropractor? Yes No

Do you have any health concerns for other family members today? _________________________________

Goals For Your Care

What would you like to gain from chiropractic care?

☐ **Relief Care** – Symptomatic relief of pain or discomfort

☐ **Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Overall Wellness Care** – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed to in writing. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Patient/Parent/Representative Signature: ____ *Date:* ____________

Current Health

What health condition(s) bring you into our office? ____

When did this condition(s) first begin? ____

How did the problem start? Suddenly Gradually Post-Injury Please Explain: ___________________

Is this condition: Getting Worse Improving Intermittent Constant Unsure

What makes the problem better? ____

What makes the problem worse? ____

Has this condition occurred before? Yes No Please Explain: _________________________________

____

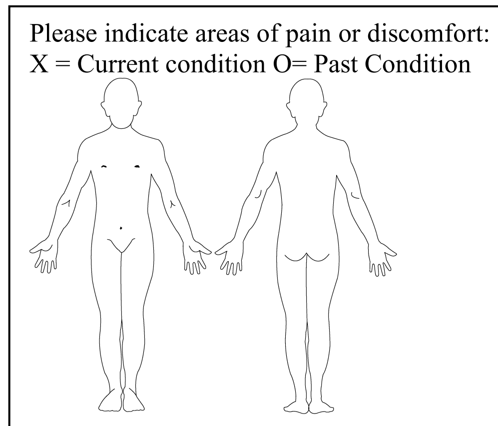
Scale of Pain

Best 1 2 3 4 5 6 7 8 9 10

Worst 1 2 3 4 5 6 7 8 9 10

Average 1 2 3 4 5 6 7 8 9 10

Please indicate areas of pain or discomfort:
X = Current condition O= Past Condition



Have you seen other providers for this condition? Yes No

Provider's Name(s) _______________________

Type of Treatment _______________________

Results ________________________________

Have you had any spinal X-rays, CAT scans or MRI imaging of your spine or head? Yes No

If yes, when and why? ____

Have you had any surgeries? Yes No If yes, please explain: ____________________________

Any significant family medical history? Yes No If yes, please explain: __________________

Are you currently experiencing a SUDDEN ONSET of any of the following symptoms?

- ☐Chest pain
- ☐Bowel or bladder changes
- ☐Sore that does not heal
- ☐Unusual bleeding or discharge
- ☐Indigestion/difficulty in swallowing
- ☐Nagging cough or hoarseness
- ☐Headaches for hours or days
- ☐Blurred vision
- ☐Night sweats
- ☐Pain in neck/jaw or face
- ☐Drooping eyelid/change in pupils
- ☐Vertigo (dizziness)
- ☐Double vision
- ☐Visual disturbances
- ☐Nausea/Vomiting
- ☐Slurred speech
- ☐Ringing in ears
- ☐Fainting

For Women Only:

Are you pregnant? Yes No

Are you nursing? Yes No

Do you have breast implants? Yes No

Have you gone through menopause? Yes No

Have you had the HPV vaccine? Yes No If yes, what age? ______________________________

Do you have painful or irregular cycles? Yes No If yes, please explain: __________________

Are you taking birth control? Yes No If Yes, what type, what age did you start, reason for starting?

____

For Doctor Use Only

Review of Systems

Please check corresponding boxes for each symptom/condition you have experienced, including both past and present.

For Doctor Use Only

Neck

Past	Present	Symptom/Condition	Past	Present	Symptom/Condition
☐	☐	Colic & Excessive Crying	☐	☐	Epilepsy & Seizures
☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
☐	☐	Allergies & Congestion	☐	☐	ADD/ ADHD
☐	☐	Immune Deficiency	☐	☐	Focus & Memory Issues
☐	☐	Headaches & Migraines	☐	☐	Anxiety & Stress
☐	☐	Vertigo & Dizziness	☐	☐	Balance & Coordination
☐	☐	Sore Throat & Strep	☐	☐	Speech Issues
☐	☐	Swollen Tonsils & Adenoids	☐	☐	TMJ/Jaw Pain
☐	☐	Vision & Hearing Issues	☐	☐	Stiff Neck & Shoulders
☐	☐	Low Energy & Fatigue	☐	☐	Depression
☐	☐	Difficulty Sleeping	☐	☐	High Blood Pressure
☐	☐	Pain, Numbness & Tingling in Arms/Hands	☐	☐	Poor Metabolism & Weight Control

Mid Back

Past	Present	Symptom/Condition	Past	Present	Symptom/Condition
☐	☐	Allergies & Eczema	☐	☐	Functional Heart Conditions
☐	☐	Chronic Colds & Cough	☐	☐	Reflux/GERD
☐	☐	Asthma	☐	☐	Indigestion & Heartburn
☐	☐	Skin Conditions/Rash	☐	☐	Stomach Pains & Ulcers
☐	☐	Bronchitis & Pneumonia	☐	☐	Blood Sugar Problems
☐	☐	Behavior Issues	☐	☐	Gall Bladder Pain/Issues
☐	☐	Hyperactivity	☐	☐	Jaundice
☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating

Low Back

Past	Present	Symptom/Condition	Past	Present	Symptom/Condition
☐	☐	Constipation	☐	☐	Sciatica & Radiating Pain
☐	☐	Crohn's, Colitis & IBS	☐	☐	Lumbopelvic/SI Joint Pain
☐	☐	Diarrhea	☐	☐	Hamstring Tightness
☐	☐	Bed Wetting	☐	☐	Disc Degeneration
☐	☐	Bladder & Urination Issues	☐	☐	Leg Weakness & Cramps
☐	☐	Cramps & Menstrual Issues	☐	☐	Poor Circulation & Cold Feet
☐	☐	Cysts & Endometriosis	☐	☐	Knee, Ankle & Foot Pain
☐	☐	Infertility	☐	☐	Weak Ankles & Arches
☐	☐	Impotency/Low Libido	☐	☐	Lower Back Pain
☐	☐	Hemorrhoids	☐	☐	Gluten & Casein Intolerance

TRAUMAS: *Physical Stress History*

Have you ever had any significant falls or other injuries as an adult? Yes No

If yes, please explain: ____

Notable childhood injuries/sports injuries? Yes No If Yes, please explain: _______________________

Any auto accidents? Yes No If Yes, please explain: ____________________________________

Exercise Frequency? None 1-2x/week 3-5x/week Daily

What types of exercise? ____

How do you normally sleep? Back Side Stomach How many hours per night? ______________

How do you wake: Refreshed and ready Stiff and tired

Do you commute to work? Yes No If yes, how many minutes per day? _____________________

Do you work from home? Yes No If yes, what is your desk ergonomic situation? ______________

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone? ______

TOXINS: *Chemical & Environmental Exposure*

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High
Water	1	2	3	4	5	Sugar/Sweeteners	1	2	3	4	5
Fruits	1	2	3	4	5	Processed Foods	1	2	3	4	5
Vegetables	1	2	3	4	5	Coffee/Energy Drinks	1	2	3	4	5
Gluten	1	2	3	4	5	Alcohol	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes/Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs that you are taking and why (Use back of page if needed.)

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THOUGHTS: *Emotional Stress & Challenges*

Please rate your STRESS for each:

	None		Moderate		High		None		Moderate		High
Home	1	2	3	4	5	Physical	1	2	3	4	5
Work	1	2	3	4	5	Personal Relationships	1	2	3	4	5
Family	1	2	3	4	5	Loss of Loved One	1	2	3	4	5

Grade Your Health

How do you grade your health?

	Poor		Fair		Good		Poor		Fair		Good
Physically›	1	2	3	4	5	Emotionally?	1	2	3	4	5
Socially?	1	2	3	4	5	Spiritually?	1	2	3	4	5

How do you grade your overall quality of life? 1 2 3 4 5

For Doctor Use Only

Authorization for Care and Patient Health Information Consent Form

AUTHORIZATION FOR CARE
I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition using adjustments and procedures the doctor deems appropriate. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

TERMS OF ACCEPTANCE
When a patient seeks chiropractic health care and we accept a person 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 person understand both the objective and the method that will be used 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 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 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 a health care provider that 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.

PATIENT HEALTH INFORMATION CONSENT FORM
We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent only needs to be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8.

Patient Name:____

__________*I have read and fully understand the above statements and I agree to the policies and procedures.*
(Initials)

*****If under 18 years old*****
Consent to provide treatment to a minor child

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

****All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. ****
I therefore accept chiropractic evaluation and recommended care on this basis.

____ ________
Patient/Parent/Representative Signature Date