Name: _____ Medical Record #: _____ Date: _____

New Patient Goals

Our mission at SpringBack Chiropractic is to find and correct the root cause of your health care concerns. Our values are to provide you with extraordinary service & to serve you with high quality care on every visit. Our vision is to unlock the potential of every patient we see in and around Surprise Arizona. We are so happy you are here!

Have you been to a chiropractor before? If so, when _____

How was your experience? _____

How did you hear about our clinic? _____

Main areas of concern & how long have you been dealing with them for?

_____

_____

_____

_____

Is this something you are serious about finding a solution for or are just curious?

_____

Diet and Nutrition

Would you say your diet is: Fair Good Great

Would you say your daily stress is: Mild Moderate Extreme

Would you be interested in discussing some potential solutions in these areas? Y/N

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Last Name: Middle: First Name:	Mr. ( ) Mrs. ( ) Dr. ( )	Miss ( ) Ms ( )	Marital Status (circle one) Single / Mar / Div / Sep/ Wid
Email:	Birth Date:	Age:	Sex:
Address:	City:	State:	Zip:
Social Sec:	Phone #:		
Occupation:	Employer:		
Please let us know who referred you:			
Medical Care Info			
Do you have a family doctor? Y/N	State:	Zip:	City:
Name of Doc:	Address:		
Date of Last Visit:	Prior Illness:		

Please list any medication allergies:			
Have you had any surgeries in the last 5 years? Y/N	Last Surgery Date:		
Reason for surgery:			
Social History			
Alcohol Y/N Drinks per week	Cigarettes? Y/N Packs per day?	Caffeine? Y/N Drinks per day?	Exercise? Y/N Hours per week? (Circle one) Light/Mod/Heavy
Daily water consumption:	Hobbies or Rec Activities:		
Smoking			
Current every day ( ) Current some day smoker ( ) Former Smoker ( ) Never ( ) Date Started: Date Stopped:			
Have you ever been treated for substance abuse or used illegal drugs? Y/N			

Medications & Supplements					
Medication/Supp Name:	Dose:	Form:	Route:	Freq:	Date Started:

Race:
White ( ) African American ( ) Asian ( ) Am Indian or AK Native ( ) Native Hawaiian or other Pacific Islander ( ) Decline ( )

Preferred Contact: Phone ( ) Email ( ) Text ( ) Fax ( ) Mail ( ) Other ( ) _____

Medical Record #: _____ Name:_____ Date: _____

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Patient Health Questionnaire

Name: _____ Medical Record #_____Date: _____

Please describe your chief concern: _____

When did it begin _____ How did it begin? _____

Description	**Frequency**	**What makes it better?**	**What makes it worse?**
( ) Sharp ( ) Numb ( ) Dull ( ) Shooting ( ) Ache ( ) Burning ( ) Weak ( )Tingling ( ) Throbbing	( ) Constant (76-100%) ( ) Frequent (51-75%) ( ) Occasional (26-50%) ( ) Intermittent (25% or less)	( ) Nothing ( ) Exercise ( ) Lying down ( ) Inactivity ( ) Walking ( ) Ice/Heat ( ) Standing ( ) Sitting	( ) Nothing ( ) Exercise ( ) Lying down ( ) Inactivity ( ) Walking ( ) Ice/Heat ( ) Standing ( ) Sitting
Indicate the intensity of your pain at it's lowest & highest level. 1----------5----------10 No Pain Unbearable	Current Weight _____lbs Height _____	Your symptoms are: ( ) Decreasing ( ) Not Changing ( ) Increasing	Worse at: ( ) Morning ( ) Night ( ) Daytime ( ) Same all day

Please rate your stress level

( ) No stress

( ) Mild stress

( ) Moderate stress

( ) Significant stress

Has this concern impacted your level of stress?

( ) Yes ( ) No

Indicate any tests or treatments that you have had for this condition (include location and year):

( ) Injection _____ ( ) Surgery _____

( ) X-rays _____ ( ) MRI _____

( ) CT/CAT Scans _____ ( ) EMG _____

( ) Physical Therapy _____ ( ) Other _____

How is your concern affecting daily activities?	**Current Work Status**	
( ) No effect ( ) Able to perform light duty only ( ) Need assistance with common tasks ( ) Inability to function without assistance ( ) Totally impaired/disabled	( ) Full time ( ) Part time ( ) Off work ( ) Restrictions	( ) Unemployed ( ) Retired ( ) Full time student ( ) Other:

( ) I have received the HIPPA Privacy Practice Act from SpringBack Chiropractic

Signature: _____ Date: _____

SPRING·BACK CHIROPRACTIC

Medical Record #: _____

Name: _____ Today's Date: _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

For Doctor/Clinic Use Only:

Doctor Signature: _____

Patients Name: _____ Medical Record #: _____
DOB: _____ /_____ /_____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery, which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures used by the practice to treat my current conditions sprain/strain injuries, irritation of a disc condition, and although rare, fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery, which could lead to a stroke. All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ /_____ / _____
Patient or Authorized Person's *Signature* Date

_____ _____ / _____ /_____
Witness *Signature* Date

_____
Print Witness Name

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CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE

This office is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation and how you may obtain access to that information. In addition, we are providing you with a list of potential circumstances under which by law, or in accordance with our office policy, we **may** disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this 'Notice' please sign the last page and return only the signature page (page 3) to our front desk receptionist.

PERMITTED DISCLOSURES

1. For treatment purposes- discussion with other health care providers involved in your care
2. *Inadvertent disclosures- services may be rendered in an open treating area, which means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.*
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
8. To Government agencies or Law enforcement, to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefits purposes.
10. Deceased persons –discussion with coroners, medical examiners and family members or others who were involved in the care or payment for care of the decedent prior to death,
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI
13. To send communications while you are being treated and we are receiving financial remuneration
14. Speaking with the patient's guardian or representative regarding bill payment
15. Providing therapy to patients in group settings
16. We may discuss your PHI using personal mobile phones when necessary to facilitate discussion about your care and or record keeping of your care.

Any other uses of disclosures not described in the Notice of Privacy Practices will be made only after obtaining your prior written authorization.

Note: *At any time, this office may update the list of ways your PHI may be used, and all updates are deemed retroactive*.

YOUR RIGHTS

1. To receive an accounting of disclosures
2. To receive a paper copy of a more detailed /comprehensive Privacy Notice
3. To request mailings to an address different than your residence
4. You have the right to request and receive electronic copies of your records
5. To request amendments to information, however like restrictions we are not required to agree to them
6. You have the right to receive notification in the event of a breach of unsecured PHI
7. To request restrictions on certain uses and disclosures and, however we are not required to comply with your request.
8. With advance notice of at least five business days to the practice you may inspect your records and receive one copy of your records at no charge.
9. You have the right to request and we as a covered entity will restrict disclosure of your personal health information to a health plan if disclosure pertains to a healthcare item or service which you have personally paid out of pocket for in full.
10. You have the right to NOT receive communications regarding fund raising and none will be sent to you unless you give us written authorization

ADDITIONAL RESPONSIBILITIES OF THIS PRACTICE

1. We are required to obtain a separate signed authorization from you before your personal health information can be used in marketing and for any disclosures that constitute a sale of personal health information.
2. We are required to notify you and HHS in the event of a breach caused by any of our business associates.
3. We are responsible to look over our business associate contracts to ensure they comply with the Omnibus Rules and requirements.
4. With prior authorization from you, we may contact you to send you information concerning products or services and information related or unrelated to your health.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Angela Powell at 480-570-4204 If she is unavailable, you may make an appointment with our receptionist to see the Doctor within 2 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

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***Continued* from page 2 of 3 →** *Patient initials* _____.

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Patient:_____ DOB: _____HR#:_____

My signature below is an acknowledgement that I have received a copy of _____ ***Chiropractic Patient Privacy Notice.*** I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of this information to the doctor and do not have any question regarding my rights or any of the information I have received at this time.

I have been made aware that additional information regarding HIPAA and my rights is published in government newsletters, which are available to me online.

The first two original pages of this 'Notice' have been given to me to keep.

_____ _____
Patient signature Date

_____ _____
Witness Date

_____ _____
Print Witness Name Date

SPRING·BACK CHIROPRACTIC

Financial Policy:

Thank you for selecting SpringBack Chiropractic for your wellness needs. We are honored to be of service to you and your family. Please be advised that payment will be due at the time services are rendered. If you should desire to submit costs associated with your care to your insurance company, SpringBack Chiropractic will provide you with the necessary codes, but SpringBack Chiropractic does not guarantee that your insurance company will reimburse any of those expenses.

Please be aware that bloodwork/labs may not be covered by insurance when ordered by a Doctor of Chiropractic. If you choose to use your insurance, you will be responsible for any balance due to the lab.

Cancellation Policy (Established Patients):

We have a 24-hour cancelation/reschedule policy. Please call or text SpringBack Chiropractic at least 24-hours prior to your scheduled appointment time to cancel or reschedule to avoid a $100.00 fee for the appointment. A valid card must be kept on file.

New Patient Policy:

Our office is extremely busy and in order to hold your new patient appointment a valid card must be kept on file to secure your first appointment. You will not be charged until your visit unless you no show or cancel in less than 24hrs prior to your appointment. No show fee is $129.00

Patient Signature Date: