Chase Chiropractic Center

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

First Name
-

Last Name
-

Cell Phone
-

Birthday
-

Gender
○ Female ○ Male

Email
-

Street Address
-

City
-

State
-

Zip Code
-

Employer
-

Type of Work
-

How long have you been working at this occupation?
-

Please check all that apply for the following sections:

Which problems have you had in the past?

- ☐ HIV / AIDS
- ☐ alcoholism
- ☐ anemia
- ☐ anorexia
- ☐ appendicitis
- ☐ arthritis
- ☐ asthma
- ☐ a bleeding disorder
- ☐ autoimmune problems
- ☐ bronchitis
- ☐ cancer
- ☐ depression
- ☐ diabetes
- ☐ emphysema
- ☐ epilepsy
- ☐ fractures
- ☐ heart disease
- ☐ hernia
- ☐ herniated disc
- ☐ high cholesterol
- ☐ kidney disease
- ☐ liver disease
- ☐ migraine headache
- ☐ miscarriage
- ☐ multiple sclerosis
- ☐ osteoporosis
- ☐ pacemaker
- ☐ pinch nerve
- ☐ pneumonia
- ☐ polio
- ☐ prostate problems
- ☐ psychiatric problems
- ☐ rheumatoid arthritis
- ☐ stroke
- ☐ suicide attempt
- ☐ thyroid problems
- ☐ tumor growth
- ☐ ulcers
- ☐ vaginal infections
- ☐ whiplash
- ☐ bulimia
- ☐ chemical dependency
- ☐ hepatitis
- ☐ venereal disease
- ☐ Other

Are you allergic to anything?

☐ corn ☐ dairy ☐ dander ☐ dust ☐ eggs ☐ gluten ☐ pollen ☐ wheat ☐ Other
☐ N/A

Which of the following is in your family history?

- ☐ HIV / AIDS
- ☐ alcoholism
- ☐ anemia
- ☐ anorexia
- ☐ appendicitis
- ☐ arthritis
- ☐ asthma
- ☐ a bleeding disorder
- ☐ autoimmune problems
- ☐ bronchitis
- ☐ cancer
- ☐ depression
- ☐ diabetes
- ☐ emphysema
- ☐ epilepsy
- ☐ fractures
- ☐ heart disease
- ☐ hernia
- ☐ herniated disc
- ☐ high cholesterol
- ☐ kidney disease
- ☐ liver disease
- ☐ migraine headache
- ☐ miscarriage
- ☐ multiple sclerosis
- ☐ osteoporosis
- ☐ pacemaker
- ☐ pinch nerve
- ☐ pneumonia
- ☐ polio
- ☐ prostate problems
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- ☐ rheumatoid arthritis
- ☐ stroke
- ☐ suicide attempt
- ☐ thyroid problems
- ☐ tumor growth
- ☐ ulcers
- ☐ vaginal infections
- ☐ whiplash
- ☐ bulimia
- ☐ hepatitis
- ☐ venereal disease
- ☐ Other
- ☐ N/A

Please check all surgical procedures you have had.

- ☐ abdominal surgery
- ☐ Abdominoplasty
- ☐ Acromioplasty
- ☐ Adenoidectomy
- ☐ Amputation
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthrodesis
- ☐ Arthroplasty
- ☐ Arthroscopy
- ☐ Bilateral cingulotomy
- ☐ Brain surgery
- ☐ Breast biopsy
- ☐ Biopsy
- ☐ Cauterization
- ☐ Cesarean section
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Clitoridectomy
- ☐ Colon resection
- ☐ Colostomy
- ☐ Colporrhaphy
- ☐ Commissurotomy
- ☐ Cordotomy
- ☐ Corneal transplant
- ☐ Cricothoracotomy
- ☐ Discectomy
- ☐ Diverticulectomy
- ☐ Episiotomy
- ☐ Endarterectomy
- ☐ Fistulotomy
- ☐ Frenectomy
- ☐ Frontalis lift
- ☐ Fundectomy
- ☐ Gastrectomy
- ☐ Grafting
- ☐ Heart transplant
- ☐ Hemorrhoidectomy
- ☐ Hepatectomy
- ☐ Hernia repair
- ☐ Hypnosurgery
- ☐ Hysterectomy
- ☐ Kidney transplant
- ☐ Khyphoplasty
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laparotomy
- ☐ Laryngectomy
- ☐ Lithotripsy
- ☐ Lobotomy
- ☐ Lumpectomy
- ☐ Lung transplant
- ☐ Mammectomy
- ☐ Mammoplasty
- ☐ Mastectomy
- ☐ Mastoidectomy
- ☐ Mentoplasty
- ☐ Myotomy
- ☐ Mryingotomy
- ☐ Nephrectomy
- ☐ Nuss procedure
- ☐ Oophorectomy
- ☐ Orchidectomy
- ☐ Penectomy
- ☐ Phalloplasty
- ☐ Pleurodesis
- ☐ Pneumotomy
- ☐ Pneumonectomy
- ☐ Prostatectomy
- ☐ Psychosurgery
- ☐ Radiosurgery
- ☐ Ritidoplasty
- ☐ Rotationplasty
- ☐ Sigmoidostomy
- ☐ Sphincterotomy
- ☐ Splenectomy
- ☐ Stapedectomy
- ☐ Thoracotomy
- ☐ Thrombectomy
- ☐ Thymectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tracheotomy
- ☐ Tracheostomy
- ☐ Tubal ligation
- ☐ Tubal reversal
- ☐ Vaginectomy
- ☐ Vasectomy
- ☐ Vivisection
- ☐ Vulvectomy
- ☐ Other

Reason for this Visit

What is the purpose of this appointment related to?

- ○ Job
- ○ Sports
- ○ Auto
- ○ Fall
- ○ Chronic Discomfort
- ○ Home Injury
- ○ Other

If job related, have you made a report of your accident to your employer?

○ Yes ○ No

Please briefly explain.

-

When did this condition begin?

-

Has this condition

- ○ Gotten worse
- ○ Stayed Constant
- ○ Comes and goes

Has this condition occurred before?

○ Yes ○ No

Does this condition interfere with

- ☐ Work
- ☐ Sleep
- ☐ Daily Routine
- ☐ Other activities

Explain

-

Doctor's Name (s)

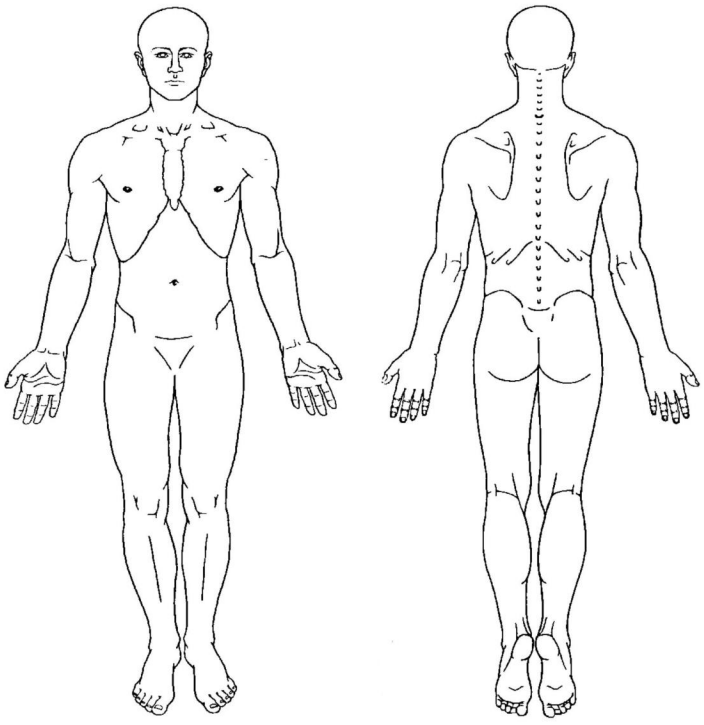
-

Type of Treatment

-

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Where is your discomfort?
-

When did this start?
-

How would you rate the level of discomfort right now on a scale of 1-10?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Since the problem began, have the symptoms been getting better, worse, or unchanged?
-

What aggravates the discomfort?
-

What relieves the discomfort?
-

Experience with Chiropractic

Have you been adjusted by a chiropractor before?
○ Yes ○ No

Doctor's Name
-

Approximate date of last visit?
-

Reason for those visits?
-

Goals for my Care

People seek chiropractic care for a variety of reasons including relief of pain, correcting the cause of pain, and correction of whatever is malfunctioning in your bodies. Your Doctor will consider your needs and desires when recommending your treatment program.
Please check the type of care desired.

Relief Care: Symptomatic relief of pain or discomfort
☐ Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms
☐ Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
☐ Yes

Please list any other goals you have for your chiropractic care.
-

Health Habits & Conditions

Please list all medications you are currently taking.
-

Do you smoke?
○ Yes ○ No

Do you drink alcohol?
○ Yes ○ No

Do you drink coffee?
○ Yes ○ No

How often do you exercise?

○ Daily ○ Weekly ○ Monthly
○ Occasionally ○ Never

Do you wear:

☐ Heel lifts ☐ Sole Lifts
☐ Inner Soles ☐ Arch Supports

Please check all health conditions that apply:

☐ Severe or Frequent Headaches
☐ Cancer
☐ Pain Between the Shoulders
☐ Lower Back Problems
☐ Heart Attack/Stroke
☐ Congenital Heart Defect
☐ Psychiatric Problems
☐ Asthma
☐ Venereal Disease
☐ Tuberculosis
☐ Anemia
☐ Sinus Problems
☐ Loss of Sleep
☐ Frequent Neck Pain
☐ Digestive Problems
☐ Thyroid Problems
☐ Heart Surgery/Pacemaker
☐ Difficulty Breathing
☐ Arthritis
☐ HIV/AIDS
☐ Shingles
☐ Dizziness
☐ Hepatitis
☐ Numbness in Arms/Legs/Hands
☐ Ulcers/Colitis
☐ Kidney Problems
☐ High/Low Blood Pressure
☐ Rheumatic Fever
☐ Alcohol/Drug Abuse
☐ Diabetes
☐ Chemotherapy

FOR WOMEN ONLY:

Are you pregnant?

○ Yes ○ No

Are you nursing?

○ Yes ○ No

Are you taking birth control?

○ Yes ○ No

Do you experience painful periods?

○ Yes ○ No

Do you have irregular cycles?

○ Yes ○ No

Emergency Contact

First Name

-

Last Name

-

Relationship

-

Home Phone

-

Nutrition and self-care are just two of the components in obtaining optimal wellness. Please let us know what you are currently doing for your health.

Things I do currently to support my health include:

☐ Drink plenty of water
☐ Acupuncture
☐ Alcohol in moderation
☐ Self-improvement books
☐ Maintain the proper weight
☐ Orthotics/Heel Lefts
☐ Annual physical examinations
☐ Exercise regularly
☐ Pray/Meditate
☐ Homeopathic remedies
☐ Eat organically grown foods
☐ Receive regular massages
☐ Use a cervical pillow
☐ Get plenty of rest
☐ Yoga/Pilates/Aerobics
☐ Maintain positive attitude
☐ Vitamins, minerals or herbs
☐ Counseling/Therapy
☐ Attend religious services

Please indicate which of these you do/have on a consistent basis:

- ☐ Eat fast food
- ☐ Work long hours
- ☐ Feel overwhelmed/Exhausted/Fatigued
- ☐ Experience gas/Bloating/Indigestion
- ☐ Experience food sensitivities/Allergies
- ☐ Periods of constipation/Loose stools/Irregularities
- ☐ History of pinched nerve/Slipped or herniated disc/Joint degeneration
- ☐ Popping/Crackling/Stiffness in your joints
- ☐ Family diagnosed with Osteoporosis/Thin brittle bones
- ☐ Muscle cramps (sports or menstrual)
- ☐ Anxiety/Nervousness
- ☐ Weak or thin/Hair/Nails/Skin
- ☐ Tooth decay
- ☐ Family history of heart disease
- ☐ Low energy/Loss of vitality
- ☐ Family history of colds/Flus/Infections/Poor immune system
- ☐ Poor gum health/Gingivitis
- ☐ Cravings for sugary foods
- ☐ Struggle with weight loss
- ☐ Lack of protein in diet
- ☐ High cholesterol
- ☐ Struggle with eating healthy throughout the day
- ☐ Currently taking vitamin supplements

Please list any vitamin supplements you are currently taking

-

Please check all that apply to you for the following sections:

General Conditions

- ☐ chills
- ☐ depression
- ☐ dizziness
- ☐ fainting
- ☐ fever
- ☐ forgetfulness
- ☐ headache
- ☐ loss of sleep
- ☐ loss of weight
- ☐ nervousness
- ☐ numbness
- ☐ sweats

Cardiovascular Symptoms

- ☐ chest pain
- ☐ high blood pressure
- ☐ irregular heart beat
- ☐ low blood pressure
- ☐ poor circulation
- ☐ rapid heart beat
- ☐ swelling of the ankles
- ☐ varicose veins

Skin Problems

- ☐ changes in moles
- ☐ bruises easily
- ☐ hives
- ☐ itching
- ☐ rashes
- ☐ scars
- ☐ sores wont heal

Ear, Nose and Throat Symptoms

- ☐ bleeding gums
- ☐ blurred vision
- ☐ crossed eyes
- ☐ difficulty swallowing
- ☐ double vision
- ☐ earache
- ☐ ear discharge
- ☐ hay fever
- ☐ hoarseness
- ☐ loss of hearing
- ☐ nosebleeds
- ☐ persistent cough
- ☐ ringing in ears
- ☐ sinus problems
- ☐ vision flashes
- ☐ vision halos

Muscle, Joint or Bone Symptoms

- ☐ none
- ☐ chest pain
- ☐ difficulty sleeping
- ☐ dizziness
- ☐ ear pain
- ☐ genital pain
- ☐ gluteal pain
- ☐ headaches
- ☐ low energy
- ☐ neck pain
- ☐ left cervical dorsal pain
- ☐ right cervical dorsal pain
- ☐ lower back pain
- ☐ middle back pain
- ☐ muscle spasm
- ☐ numbness and tingling
- ☐ pain between shoulder blades
- ☐ soreness
- ☐ stomach pain
- ☐ stress
- ☐ throat pain
- ☐ tightness
- ☐ tiredness
- ☐ upper back pain
- ☐ right hip pain
- ☐ left hip pain
- ☐ right leg pain
- ☐ left leg pain
- ☐ right knee pain
- ☐ left knee pain
- ☐ right ankle pain
- ☐ left ankle pain
- ☐ right foot pain
- ☐ left foot pain
- ☐ right shoulder pain
- ☐ left shoulder pain
- ☐ right arm pain
- ☐ left arm pain
- ☐ right elbow pain
- ☐ left elbow pain
- ☐ right wrist pain
- ☐ left wrist pain
- ☐ right hand pain
- ☐ left hand pain
- ☐ right arm numbness and tingling
- ☐ left arm numbness and tingling
- ☐ right leg numbness and tingling
- ☐ left leg numbness and tingling

Gastrointestinal Symptoms

- ☐ bloating
- ☐ constipation
- ☐ diarrhea
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ gas
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea
- ☐ poor appetite
- ☐ rectal bleeding
- ☐ stomach pain
- ☐ vomiting
- ☐ vomiting blood
- ☐ N/A

Genito-Urinary Symptoms

- ☐ blood in urine
- ☐ frequent urination
- ☐ lack of bladder control
- ☐ painful urination
- ☐ N/A

For males:

- ☐ breast lump
- ☐ erection difficulties
- ☐ lump in testicles
- ☐ penis discharge
- ☐ sore on penis
- ☐ N/A

For females:

- ☐ abnormal pap smear
- ☐ bleeding between periods
- ☐ breast lump
- ☐ extreme menstrual pain
- ☐ hot flashes
- ☐ nipple discharge
- ☐ painful intercourse
- ☐ vaginal discharge
- ☐ N/A

How long have you been experiencing these symptoms?

-

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week. It is our policy that if a patient misses or canceled an appointment with less than 24 business hours notice, that patient will be charged a $25.00 fee (subject to change) for that time slot.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Authorization for Care:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Good Faith Estimate:

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

If you do not have insurance or choose not to use your insurance, Chase Chiropractic Center will provide a “Good Faith Estimate” (“GFE”) of how much our services will likely cost you upon request. If you are paying us directly for your services and you schedule at least 3 days in advance, we will provide a written GFE within 1 day of scheduling. If you schedule more than 3 days in advance, we will provide a written GFE within 3 business days after scheduling. To facilitate this we will send the GFE by e-mail if you provide an e-mail address.
We will inform you in advance with a new GFE if we plan to increase our fees or we anticipate your costs exceeding your original GFE. If we don’t and we bill you more than $400 in excess of your GFE without informing you in advance, you will have a right to dispute our bill through a federal dispute resolution process. You will need to provide a copy of your GFE to open a dispute, so we recommend that you save and/or print your GFE for future reference.

To request a GFE, please contact us at clinic@chasechiro.net or by phone (586)774-0091.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

PLEASE NOTE:

- A Good Faith Estimate under this law is only applicable to uninsured individuals or individuals who choose not to bill their insurance and pay out of pocket.
- A Good Faith Estimate is an ESTIMATE. It is not defining of what the actual charges may be.
- A Good Faith Estimate is not a contract or "promise" to provide services for that estimated cost.
- There may be additional services or items needed in the care of a patient that are not listed in the Good Faith Estimate. When those situations arise a separate GFE will be provided for those services or items and those charges will be above and beyond the existing GFE.
- The patient always has the right to decline any services if the Good Faith Estimate is more than the patient might expect or choose to accept.
- A person who has insurance but has not used it for the some of the period covered by the GFE, may choose later to start billing services to the insurance carrier. When this is done, the previously provided services under the GFE will not be billable to the insurance, but any further services after notification will be billed to the insurance. This choice also voids the GFE and any ability to dispute the charges through the No Surprises Act.
- If the charges for the listed services within a Good Faith Estimate exceed the estimate by more than $400, the patient has the right to file a patient-provider dispute resolution process through the Federal Site listed above. If a patient initiates such a dispute, it will not interrupt the care nor create any change in the quality of care provided while the matter is being settled.
- If there is a dispute the patient and provider can work together to find a resolution without resorting to the Federal resolution process.
- If a patient has any unanswered questions about the Good Faith Estimate or any of the patient's rights under the No Surprises Act, we will be happy to discuss these and provide guidance to the Federal Resolution process.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Photo Consent

I understand and consent to Chase Chiropractic Center taking and using photographs of me for the purposes of evaluating my progress and for promotional content, including social media and marketing materials. I understand that my identity will be kept confidential, and I will not receive compensation for the sue of these images. I understand that I can revoke this consent at any time through a written request, but this will not affect photos taken prior to my revocation, nor will my care be affected by the decision.

Signature	Date Signed -
Printed Name -	Email -