McCORMICK chiropractic

Adult Chiropractic Health Questionnaire

Welcome to our office! It is well known that families who maintain strong healthy, well- aligned spines have much-improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Name _____ Home Phone _____

Address _____ Work Phone _____

City_____ State_____, Zip_____ Cell Phone_____

Birth date_____ Age _____ SS#_____ Male_____ Female_____

Occupation Employer _____

Employer's Address_____Phone # _____

Marital Status: M W Sep. D Sin. Spouse Name_____ No. of Children _____

Spouse's Employer _____

Spouse's Birth date: _____ E-mail Address _____

1. Most patients are referred to our office by a caring family member or friend.

What made you decide to visit our office?
☐ Friend/Family Member Name ☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that your spine should be checked regularly.
How many times have you visited a chiropractor in your lifetime?_____ ☐ Never

3. When was your last complete spinal examination including x-rays?_____ ☐ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking.
Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back.
Do you ever feel the need to crack or pop your neck or lower spine? □ YES □ NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.

1._____

2._____

3._____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

_____

_____

_____

11. Auto and work-related injuries can cause serious spinal problems.

Is this visit related to an accident or injury? □ YES □ NO Date of Incident:_____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? □ YES □ NO

13. Have you ever been diagnosed with cancer? □ YES □ NO Type_____ Year_____

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? □ YES □ NO

Do you have health insurance? _____

Name of Company_____

Subscriber's Name _____ Date of Birth _____

Subscriber's relationship to Patient: _____ Subscriber's SS# _____

Subscriber address: _____ City_____ State____
Zip_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Authorization Signature_____ Date_____

All of the above patient information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____

ONLY For Patients Under the Age of 18 Years Old

Consent to Treatment of Minor Child

I hereby authorize McCormick Chiropractic of Pottstown, PA and whomever they may designate as assistants to administer Chiropractic Care as deemed necessary to my _____ (indicate relationship of child),

Name of child_____

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name:_____ Phone: _____ Cell:_____

Name of Parent/Guardian responsible for Patient's Account: _____

Address (if different from address of patient): _____

Phone: _____ Cell:_____

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HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a health care facility to obtain a patient's written consent before using or disclosing the patient's personal health information (PHI) to carry out treatment, payment, or health care operations.

Please read the consent statement below and sign that you understand its provisions:

- **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.**
- **The patient has a right to review our Notice of Privacy Practices for Protected Health Information.**
- **The patient has a right to request restrictions with the use of an authorization form**
- **The patient has a right request in writing to copy or inspect certain PHI**
- **The patient has a right to revoke consent in writing**

*We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read our complete **HIPAA Notice of Privacy Practices for Protected Health Information** that is available to you at the front desk before signing this consent.*

I have read and give consent to treatment under the HIPAA provisions of the office.

Signature:_____

Printed Name: _____

Date: _____