Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work Phone ( ) _____

Email Address _____ Male_____ Female _____

Social Security # _____ Driver's Lic.# _____ Birthdate _____

Occupation/Employer's Name and address _____

Single____ Married____ Divorced____ Widowed____ Spouse's Occupation/Employer _____

No. of children:____ (In Canada) Health Card#_____ Version Code: _____

Reason for consulting our office?_____

Who may we Thank for referring you to our office?_____

YOUR HEALTH PROFILE

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

ADULT - (18 TO PRESENT)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do /did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CARFULLY.

As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment & Payment Purposes
We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or a medical billing clearinghouse or collection agencies for the purpose of payment of your health care services. This office utilizes an outside billing service.

Workers' Compensation
We may disclose your health information as necessary to comply with state Work Comp Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Other
As required by law, we may disclose your health information to the following persons or entities:

- Public Health Authorities
- Law Enforcement Officials
- Medical Examiners or Coroners
- Approved Medical Research or Review Board
- Public Safety Officers
- Specialized Government Agencies

Communications
We may contact you for additional communications, or other purposes, as described below:

It is our policy to call your home on the day prior to your scheduled appointment to remind you or your appointment time. A reminder message is left with a person or answering machine if you are not at home.

Birthday cards and/or seasonal greeting cards are sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift or medical reminders. These greeting cards are often post cards and are not enclosed in a sealed envelope. In the office, you maybe asked to sign in and your name may be called out loud. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy.

Change of Ownership
In the event that this practice is sold or merged with another organization, your health record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by our office.
- You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office manager.

Complaints

Complaints about your Privacy Rights, or how our office handles the use or disclosure of your health information should be directed to our office manager.

If your are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of __/__/____

I have read the Privacy Notice and understand my rights contained in the notice.

Patient's Name (print) _____ Signature _____ Date _____

EXPLANATION OF PROFESSIONAL FEES

CONSULTATION: No Charge
The consultation takes place subsequent to the New Patient History Examination. The Doctor will discuss with the patient any current complaints. The Doctor will also give the patient a brief explanation of Chiropractic and the care they will be receiving.

CHIROPRACTIC EXAMINATIONS:

NEW PATIENT HISTORY EXAMINATION: $50.00-$150.00
A case history on the new patient involves questions regarding their past and present health complaints. The Doctor will also perform various range of motion, orthopedic, neurological and/or chiropractic tests.

BRIEF EXAMINATION: $40.00-$80.00
Consists of the Doctor questioning the patient as to their subjective status, prone and supine leg length differential tests, Derefield, spinal motion palpation and Cervical Syndrome tests to determine the patients' status objectively. Based on the above, the Doctor determines whether the patient requires a corrective adjustment on that visit.

ESTABLISHED PATIENT RE-EXAMS: $60
Subsequent to the 12-15th visit, the Doctor will perform several Chiropractic tests so that she may further evaluate the patients' progress.

CHIROPRACTIC X-RAY STUDIES: $75.00-$175.00
Subsequent to the consultation, and after careful review of the patients' complaints, the Doctor will determine if x-rays are necessary for the proper care of the patient.

CHIROPRACTIC ADJUSTMENT: $40.00-$95.00
The Chiropractic Adjustment is the correction (reduction) of a subluxated vertebra or pelvic segment by means of making a specific, predetermined adjustment. The Chiropractic Adjustment is made only after careful analysis, delivered in a specific manner, to achieve a predetermined goal. It is a precise, delicate maneuver, requiring special bioengineering skills and deftness.

SIGNATURE _____ **DATE** _____

CHIROPRACTIC CONNECTION
DR. DANA TANKELL

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient 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 patient 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 disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interface 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 the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

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.

I, _____ have read and fully understand the above statement.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian
of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

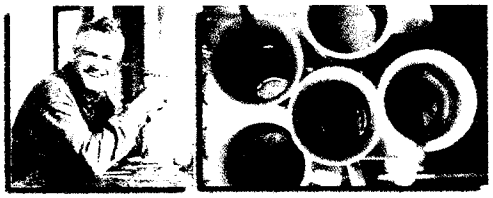
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____.

Signature and Date_____

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:



Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**
About ___ cups.

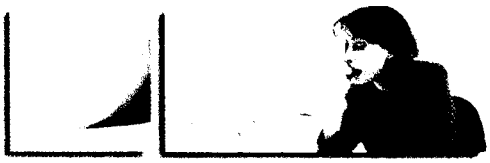
Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____ .

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

❑ **No** ❑ **Yes:** _____.



Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes:** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**

Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing any type of emotional turmoil? ❑ **No** ❑ **Yes**