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CHIROPRACTIC + WELLNESS CENTER

ADULTH HEALTH HISTORY

Name of Patient			Date
Gender	Male ☐	Female ☐	Date of Birth / / Age
Address			
Address			
Phone Numbers: Home ( ) -		Work: ( ) -	Cell: ( ) -
Occupation			
Emergency Contact Name:			Emergency Contact Number: ( ) -
Email			

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.

Mother's highest education level:			
Father's highest education level:			
Please check any box that applies:			
Has anyone in the family had:	***Siblings***	***Parents***	***Extended Family***
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

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Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

BIRTH HISTORY

Do you have any information with regard to your birth history? _____

_____

DEVELOPMENTAL HISTORY

Do you have any information with regard to your infant health status?
For example, where you hospitalized, or had any serious health issues?

_____

_____

_____

_____

MEDICAL HISTORY

Are you regularly checked by the following:

___Medical Doctor ___Chiropractor ___Osteopath ___Naturopath ___Dentist ___Other

Do have/had braces on your teeth?	___Yes	___No
Do you have any amalgam fillings? How many?	___Yes	___No
Do you complain of any ongoing physical pains? (headaches, stomach aches, muscle/joint aches, or growing pains)	___Yes	___No
Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination?	___Yes	___No

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Please list all of you medical and/or psychological diagnoses, past and present:

_____

_____

_____

_____

Please list all current prescription medications:

_____

_____

_____

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)? ___Yes ___No

Have you had any serious falls, physical traumas, or physical injuries? ___Yes ___No
Please list:

_____

_____

_____

Have you ever been involved in a motor vehicle accident? ___Yes ___No
Please list:

_____

_____

_____

_____

Has your hearing ever been tested? ___Yes ___No
When was your last hearing test? _____
Has your vision been tested? ___Yes ___No
When did you last visit the optometrist? _____
Do you wear glasses/contact lenses? ___Yes ___No
Have you been hospitalized? ___Yes ___No
If Yes, for what? _____

_____

Have you had any surgeries? ___Yes ___No
If Yes, what reason? _____

_____

_____

Have you had any surgeries recommended to you that have not been performed? ___Yes ___No
If Yes, for what? _____

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Have you had prior psychotherapy or counseling? ___Yes ___No

If Yes, for what issue? _____

BEHAVIOR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level (circle one)

Personal	1	2	3	4	5	6	7	8	9	10
Occupational	1	2	3	4	5	6	7	8	9	10

Describe any sports or activities you are involved in.

Indicate the number of hours a week of "screen time" you use:

Computer _____ Smart Device (phone, iPad, etc.) _____

Computer games (DS, etc.) _____ Television _____

Describe your family relationships; with parents and siblings.

Do you have many friends? _____

Do you excel at, or struggle to build relationships with your peers? ___Excel ___Struggle ___Neither

If you struggle, why do you think that is?

What problems do you have with peers, if any?

___None ___Bragging to peers ___Being teased

___Being physically attacked ___Rejected by peers ___Overly physically affectionate

___Being bullied ___Jealous of peers

Do you have self esteem issues? ___Yes ___No

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Do you feel that you exhibit any of the following symptoms more often than is typical? (Please check any that apply)

___Often touchy/easily annoyed
___Often defies rules
___Often angry/resentful
___Often argues with adults
___Often looses temper
___Blames others for mistakes
___Deliberately annoys
___Often spiteful/vindictive
___Refuses to go to work
___Repeated nightmares
___Unusual fears
___Panic attacks
___Self-conscious/clings
___Excessive need for reassurance
___Self-injurious behavior
___Worry of future events
___Repeats certain actions
___Somatic complaints (headache/stomach)
___Difficulty maintaining friendships
___Often bullies/threatens
___Initiates physical fights
___Ever been arrested
___Physically cruel to others
___Physically cruel to animals
___Motor or vocal tics
___Destroys property
___Deliberately sets fires
___Lies often
___Steals
___Has run away
___Extreme mood swings
___Does not show emotions
___Overreacts to touch/noise
___Strange or bizarre ideas
___Used drugs in the past
___Poor social interactions
___Gets upset by changes in routine
___Often irritable
___Changes in appetite
___Diminished interest
___Sleep problems
___Restlessness or slowed down
___Fatigues/low energy
___Feels worthless
___Becomes tearful easily
___Often sad
___Indecisive/can't think
___Thinks about death
___Talks about suicide
___Hurts self
___Currently uses drugs
___Currently drinks beer or alcohol
___Used beer or alcohol in the past
___Can't stop thinking about things
___Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes you:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities				
Often has difficulty sustaining attention in tasks or activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish tasks, (not due to oppositional behavioral failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				

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Often moves excessively in situations where it is inappropriate (may be limited to subjective feelings or restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or activities)				

Childhood conditions had, please check:

___Measles ___Mumps ___Chicken Pox ___Whooping cough

___Scarlet Fever ___Diphtheria ___Rheumatic fever ___Typhoid fever

___Ear Infections ___Tubes in ears ___Chronic illness

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

HABITS OF LIFESTYLE

Do you smoke? ___Yes ___No Do you exercise? ___Yes ___No

Do you consume alcohol? ___Yes ___No Exercise Indoor Activities: _____

_____

Exercise outdoor Activities: _____

_____

Approximate sleep hours per night (check one): ___4-6 ___6-8 ___8-10 ___12+

Rate your sleep hours per night (check one): Do you wake rested? ___Yes ___No

Rate your appetite: ___Poor ___Fair ___Medium ___Good ___Excellent

Rate your diet: ___Poor ___Fair ___Medium ___Good ___Excellent

Do you eat regularly: ___Breakfast ___Lunch ___Dinner

Do you eat per day: ___1 meal ___2 meals ___3 meals ___4meals ___Over 4 meals

Do you take vitamins and minerals? ___Yes ___No

If yes, please list: _____

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Do you take any recreational drugs? ___Yes ___No
If so, what? _____

Have you ever been knocked unconscious: ___Yes ___No ___Don't know
If so, for how long? _____

O	F	C	General
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fevers
			Headaches
			Loss of sleep
			Nervousness
			Depression
			Neuralgia
			Numbness
			Sweats
			Loss of weight
			Tremors
O	**F**	**C**	**Muscle & Joint**
			Arthritis
			Bursitis
			Foot trouble
			Hernia
			Low back pain
			Neck pain
			Neck stiffness
			Pain between shoulders
O	**F**	**C**	**Respiratory**
			Chest pain
			Chronic cough
			Difficulty breathing
			Spitting blood
			Throat phlegm
			Wheezing
O	**F**	**C**	**Eyes, Ears, Nose & Throat**
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Asthma
			Ear aches
			Ear discharges
			Ear noises
			Sinus infections

O	F	C	Eyes, Ears, Nose & Throat
			Tonsillitis
			Eye pain
			Failing vision
			Far sighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Near sighted
			Nosebleeds
O	**F**	**C**	**Cardio-Vascular**
			Rapid heart beat
			Slow heart beat
			Swelling of ankles
			Hardening of arteries
			High blood pressure
			Pain over heart
			Poor circulation
O	**F**	**C**	**Gastro Intestinal**
			Excessive hunger
			Burping or gas
			Liver trouble
			Colitis
			Colon trouble
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Stomach pain
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Poor appetite
			Nausea
			Vomiting
			Vomit blood
O	**F**	**C**	**Skin**
			Boils
			Bruise easily
			Dryness
			Hives or allergy

O	F	C	Skin
			Itching
			Skin rash
			Varicose veins
O	**F**	**C**	**Genito-Urinary**
			Bed wetting
			Blood in urine
			Frequent urination
			Loss control urine
			Kidney infection
			Painful urination
			Prostate trouble
			Pus in urine
			Smell of urine
O	**F**	**C**	**Pain or Numbness in:**
			Shoulders
			Arms
			Hips
			Legs
			Knees
			Ankles
			Feet
			Painful tail bone
			Sciatica
			Swollen joints
O	**F**	**C**	**For Women Only**
			Cramps
			Heavy flow
			Light flow
			Irregular cycle
			Painful cycle
			Discharge
			Sore breasts

Menopausal: ___Yes ___No
Last Menstruation Date: _____

Pregnant: ___Yes ___No
Due Date: _____

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific question do you have that you hope an evaluation will answer?

Signature_____ Date: _____/_____/_____

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INSURANCE INFORMATION:

Member ID# _____

Insurance Company: ❑BC/BS (PPO) ❑Medicare ❑Coventry ❑United Health Care ❑ Aetna

❑Other _____

Policy Holder: ❑ self ❑spouse/partner ❑parent ❑guardian

_____

Policy Holder Name (if not self) DOB

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Heartland Chiropractic and Wellness Center all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

SIGNATURE

Acknowledgment of Heartland Chiropractic and Wellness Center Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me.
I also understand that this Notice is available at HeartlandWellnessCenter.com\Forms or by request.

_____

Signature of Patient or Legal Representative *Date*

_____

Print Name of Patient or Legal Representative

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_____

Signature of Patient or Legal Representative *Date*

_____

Print Patient Name

5521 NW 86th St. Johnston · IA 50131 · Phone: 515.252.8668 · fax: 515.270.2457 · info@hcwellness.com
www.HeartlandWellnessCenter.com

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5521 N.W. 86th Street · Johnston, IA

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the

preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

_____

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

No Show and Cancellation Policy

Thank you for trusting your medical care to Heartland Chiropractic & Wellness Center. When you schedule an appointment with Heartland Chiropractic & Wellness Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Initial	Please read the following closely and initial when finished
x_____	**Cancellation & No Show Policy:** Heartland Chiropractic and Wellness Center has a 12-hour cancellation & rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 12 business hour notice, you will be charged $30.00. If you no-show or late cancel for two or more visits, you will receive a $50.00 fee. This policy is out of respect for our doctors and our patients in order to help as many individuals as possible. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
x_____	**Late Arrivals:** If you arrive late (10+ minutes) to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.
x_____	**Terms & Conditions:** I understand the terms of this form. I understand that these fees are not related to my insurance coverage, co-pay, or deductible and cannot be billed to my insurance company.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact Heartland Chiropractic & Wellness Center during our regular business hours with any questions or concerns regarding our policies.

515-252-8668 · info@hcwellness.com · 5521 NW 86th St. · Johnston, IA 50131
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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 19th, 2013

This Notice of Privacy Practices applies to the following organizations.

Heartland Chiropractic and Wellness Center Privacy Official:
Stephanie Sandvig, Office Manager steph@hcwellness.com 515.252.8668