Ignite Life Chiropractic

N a m e

_____ Date ____/____/____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Phone: Home_____ Cell _____ Carrier (Ex: AT&T, Verizon)

For reminders do you prefer Phone Calls, Text Messages or Emails? CALL ME / TEXT ME / EMAIL ME

Email Address _____ Date of Birth _____/_____/_____

Social Security Number _____-_____-_____ If a minor, parent/guardian SSN _____-_____-_____

Occupation _____ Name of Employer _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

Do you independently make your own financial decisions for your Health Care? Circle: Yes No
If not, please provide your parent/guardian Name, Phone Number, and Best Time to be Reached that makes the Financial Decisions regarding you Health Care: _____

Who may we thank for referring you? _____

YOUR HEALTH:

Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would like your health and wellness to be.

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List According to Severity	Rate of Severity 1-Mild 10-UNBEARABLE	When did this episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are Symptoms Intermittent or Constant?
1.					
2.					
3.					
4.					

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE_____

_____

_____

IF YOU ARE EXPERIENCING PAIN, IS IT: SHARP _____ DULL _____ BURNING _____

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? CIRCLE: YES NO

IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE ITS PATTERN _____

_____

SINCE YOUR PROBLEM STARTED, IS IT: THE SAME _____ GETTING BETTER _____ GETTING WORSE _____

WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

WHAT HAVE YOU DONE THAT MAKES IT BETTER?

_____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? CHIROPRACTOR ____ MD ____ OTHER ____

NAME & PHONE NUMBER OF PREVIOUS DOCTOR

_____

LIST SURGICAL OPERATIONS AND YEARS

_____

_____

LIST ALL MEDICATIONS YOU ARE ON

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT

_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? CIRCLE: YES NO

IF YES, DR. & LAST VISIT DATE

_____

HAVE YOU EVER BEEN UNCONSCIOUS? CIRCLE: YES NO

HAVE YOU EVER FRACTURED A BONE? CIRCLE: YES NO

IF YES, PLEASE DESCRIBE

_____

ANY OTHER BODILY TRAUMA?

_____

PLEASE CIRCLE AN AND ALL CURRENT PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS

ASTHMA	ARTHRITIS	TMJ	CHRONIC FATIGUE
EPILEPSY	GASTRIC REFLUX	HEART DISORDERS	LUPUS
ULCERS	SCIATICA	IRRITABLE BOWEL	NAUSEA
DIZZINESS	NUMBNESS IN ARMS	DISC PROBLEMS	MENSTRUAL DISORDER
KIDNEY PROBLEMS	NUMBNESS IN HANDS	LIVER DISEASE	NECK PAIN
HEADACHES	NUMBNESS IN LEGS	LOW BACK PAIN	MIGRAINES
VERTIGO	NUMBNESS IN FEET	MID BACK PAIN	STIFFNESS IN NECK
CHEST PAINS	EAR INFECTIONS	STOMACH DISORDER	HIP PAIN
ARM PAINS	GRATING IN NECK	LEG PAIN	ANXIETY
NERVOUSNESS	SHOULDER PAIN	FAINTING	CHRONIC SINUS
DEPRESSION	INSOMNIA	NERVOUSNESS	BLADDER DISORDER

OTHER _____

LIST SYMPTOMS/COMPLAINTS IN ORDER OF DISCOMFORT

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW/HAVE HAD IN THE PAST:

STROKE	CANCER	HEART DISEASE	SPINAL SURGERY
SCOLIOSIS	DIABETES	SEIZURES	SPINAL BONE FRACTURE

DO YOU HAVE INSURANCE? **CIRCLE: YES NO**

IF YES, WHAT IS THE NAME OF YOUR INSURANCE COMPANY AND ACCOUNT NUMBER?

_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUR AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD / MINOR

NAME OF PATIENT WHO IS A MINOR/CHILD: _____

I AUTHORIZE DR. JOSHUA BYERS AND ANY AND ALL IGNITE LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR / CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD, IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY SIMS CHIROPRACTIC.

_____

GUARDIAN SIGNATURE **DATE**

_____

GUARDIANS RELATIONSHIP TO MINOR / CHILD **WITNESS SIGNATURE (OFFICE STAFF)**

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF IGNITE LIFE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, THEY WILL BE BROUGHT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT YOUR NAME HERE **DATE**

_____ _____
SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE **I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT IGNITE LIFE CHIROPRACTIC.

_____ _____
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

CA Initials:
_____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**