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_____

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.

_____ _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities (payers), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, Longworth Chiropractic and Sports Injuries," Longworth Chiropractic" or "office" such sums as may be owing to Longworth Chiropractic for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Longworth Chiropractic with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Longworth Chiropractic to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorists coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Longworth Chiropractic, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Longworth Chiropractic to extent of my charges, as well as any and all cases of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to prompt pay such Office, and to provide a full accounting of such funds to the Office upon request.

I hereby direct all payers to release to Longworth Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Longworth Chiropractic to endorsee/sign my name on any and all checks listing me as the payee which are presented to this Office fr payment of an account relating to me, my spouse, or any of my dependents. I further authorize Longworth Chiropractic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Longworth Chiropractic for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Longworth Chiropractic for all costs of such collection efforts , including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual consent of Longworth Chiropractic and myself., I hereby revoke any previously signed authorizations, whether executed at this office or at any other office to the extent of theat the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Longworth Chiropractic and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portion and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print):_____

Patient Signature:_____Date:___/___/____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____Date:___/___/____

CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or any other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below. **I ALSO AGREE TO INFORM THE DOCTORS IF I AM PREGNANT OR BELIEVE TO BE PREGNANT.**

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been an answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient or patient's representative:

_____
Patient Name (printed)

_____ _____
Patient Signature Date

_____
Parent/Guardian Name (printed)

_____ _____
Parent/Guardian Signature Date

To be completed by doctor or staff:

_____
Witness to Signature

PRACTICE'S REQUIREMENTS

Dr. CRAIG W. LONGWORTH D.C

THE PRACTICE:

A. Is required by federal law to maintain the privacy of your PHI and to provide to you with the Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

B. Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI then that which is provided for under federal law.

C. Is required to abide by the terms of this Privacy Notice.

D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

E. Will distribute any revise Privacy Notice to you prior to implementation.

F. Will not retaliate again you filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 9/2/2003

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Signature:_____

Date: _____