ABILITY CHIROPRACTIC

634 N. STATE STREET, WESTERVILLE OH, 43082 (614) 901-WELL www.abilitychiro.com

Name:_____ Age:_____ Date:_____

Address:_____ City:_____State:_____ Zip Code:_____

Alternate Address:_____ City: _____ State:_____ Zip Code:_____

Cell Phone: (  )_____ Cell Phone Provider:_____ Male:____ Female:_____

Social Security #_____ Birth date:_____

Occupation: _____ Employer:_____

Email: _____ Work Phone: (  )_____

Single:_____ Married:_____ Divorced:_____ Widowed:____ Student:_____

How did you hear about us?_____

## Your Health Profile

Welcome to Ability Chiropractic! Our goals are, first, to address the health concerns that brought you to this office, second, to offer you the opportunity to improve your overall health potential and well-being, and third, to answer any questions that you might have. Answering the following questions will give us a health profile allowing us to better assess your condition and help us address your current needs.

## Childhood Years

Research is showing that many of the health challenges that we face today have their origins during our developmental years, some starting as early as birth. Please answer the following to the best of your ability.

| | Yes | No |
|---|---|---|
| Was your birth C-section, suction or forceps? | ☐ | ☐ |
| Did you have any serious childhood illnesses? | ☐ | ☐ |
| Did you experience any abuse (physical or verbal) as a child? | ☐ | ☐ |
| Did you experience any sports injuries as a child? | ☐ | ☐ |
| Any childhood falls or accidents? (car, crib, tree, bike, bed….) | ☐ | ☐ |
| Was there any prolonged use of medications such as antibiotics, inhalers, Ritalin? | ☐ | ☐ |
| Did you suffer any emotional trauma or significant loss as a child? | ☐ | ☐ |
| Were you checked for traumatic birth syndrome? | ☐ | ☐ |

## Adult Years

On a daily basis we experience physical trauma, chemical toxins and emotional stresses that can accumulate and result in a serious loss of our health potential. In most cases the effects are gradual, not even felt until they become serious.

| | Yes | No |
|---|---|---|
| Do/ Did you smoke? | ☐ | ☐ |
| Do/ Did you drink alcohol? | ☐ | ☐ |
| Have you been involved in any accidents (car, work, sports, falls)? | ☐ | ☐ |

If so, please describe:_____

_____

Do you participate in extreme sports? _____

Please list any surgery that you've had:_____

_____

List all medications that you are taking:_____

_____

## Your Current Health Status

On a scale of 1-10 rate your current state of health: (1=poor/ 10=excellent) _____

| | Yes | No |
|---|---|---|
| This visit is for a Wellness Evaluation: | ☐ | ☐ |
| This visit is for a specific area of complaint: | ☐ | ☐ |

List your chief complaints in order of severity:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Where is the pain? _____

Does the pain radiate: _____

Is your discomfort: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Come and Goes ☐ Constant

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

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Family life

Other health care providers seen for this condition:

- ☐ Chiropractor:_____
- ☐ Medical Doctors:_____
- ☐ Other:_____

**Patient's or Authorized Person's Signature**-I authorize Ability Chiropractic to contact my primary care or other health care provider regarding my care and the release of any medical records or other information as necessary.

**Signature:**_____ **Date:**_____

## Please Check All That Apply

Please check all symptoms you have ever had, even if they don't seem related to your current problem.

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Pins and needle in legs | ☐ Fainting | ☐ Neck Pain |
| ☐ Pins and needles in arms | ☐ Back pain | ☐ Loss of balance | ☐ Dizziness |
| ☐ Ringing in the ears | ☐ Nervousness | ☐ Numbness in fingers | ☐ Tension |
| ☐ Numbness in toes | ☐ Upset Stomach | ☐ Frequent colds | ☐ Fatigue |
| ☐ Depression | ☐ Irritability | ☐ Sleeping problems | ☐ Stiff neck |
| ☐ Cold hands or feet | ☐ Heart burn | ☐ Lack of concentration | ☐ Mood swings |
| ☐ Menstrual problems | ☐ Prostate problems | ☐ Chronic fatigue | ☐ Diabetes |
| ☐ Inability to lose weight | ☐ Cardiovascular disease | ☐ High blood pressure | ☐ Asthma |
| ☐ Arthritis | ☐ Bladder problems | ☐ Bronchitis | ☐ Whiplash |
| ☐ Carpal tunnel syndrome | ☐ Colon problems | ☐ Disc problems | ☐ Migraines |

## 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 your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Wellness Chiropractor, please mention their name and condition below:

Children:_____
Spouse:_____
Mother:_____
Father:_____
Brothers or sisters:_____
Others:_____

## Your Wellness Profile

| | Yes | No |
|---|---|---|
| Do you belong to a health club/gym? | ☐ | ☐ |
| Do you take vitamins? | ☐ | ☐ |
| Do you meditate? | ☐ | ☐ |
| Do you practice yoga? | ☐ | ☐ |

## X-Ray Consent (All Patients)

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.

_____ _____

Patient Name (if under 18) Date

_____ _____

Signature of guardian/patient Date

## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. I understand that results are not guaranteed. My condition may or may not improve with chiropractic care. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

**Chiropractic** is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I have been offered a copy of the Notice of Privacy Practices for Protected Health Information. _____
Initial

**The information made on this form is accurate and I agree to allow this office to examine me for further evaluation:**

**Signature:_____ Date:_____**

## Health Insurance / Payment for Services Rendered

### PAYMENT IS DUE AS SERVICES ARE RENDERED

Patients are responsible for payment at the time of their visit. Understand that health and accident insurance policies are an arrangement between an insurance company and you. Ability Chiropractic accepts assignment of insurance benefits, and as a courtesy we will verify your insurance. We will inform you of how much we anticipate your insurance to contribute to your care, but verification is not a guarantee of payment.

**Patient's or Authorized Person's Signature**-I authorize the release of any medical or other information necessary to my insurance carrier to process my claims. I also request insurance payments be made directly to Ability Chiropractic Inc. I am aware that health insurance may deny coverage of care and I agree to pay for any denied services.

Signature _____ Date_____

Insurance company: _____ Policy #: _____
Group #: _____ Insurance Phone: _____

## Medicare

Ability Chiropractic is a participating Medicare provider. Medicare patients must present their Medicare card at the onset of treatment. Chiropractic coverage by Medicare includes adjustments only. For any other services, patients are required to pay cash as services are rendered. If you have a secondary insurance, please present that card with your Medicare card at the onset of treatment and we will verify your coverage and submit your claims as a courtesy to you.

**Patient's or Authorized Person's Signature**-I authorize the release of any medical or other information necessary to Medicare. I also request payment of government benefits to Ability Chiropractic Inc. I am aware that Medicare may deny coverage of care and I agree to pay for services not covered by Medicare.

Signature _____ Date_____