EAGLE CHIROPRACTIC SHAWN H. NORD D.C.

5337 W. State St. Eagle, ID 83616 Phone# (208)939-9195 Fax#(208)939-4686

PATIENT HEALTH HISTORY

Name: _____ Birth date _____/_____/_____ Age _____

Address: _____ Sex: ____ Male ____ Female

City: _____ State_____ Zip_____ Home phone: _____ Cell: _____

Social Security #: _____ Driver's License # and State: _____

Employer: _____ Email Address: _____

Business Phone #: _____ Occupation: _____

__ Married __ Single __ Divorced __Widowed Spouse Name: _____

Spouse employer: _____ Number & Ages of Children: _____

Referred to this office by: _____ _____

Name of emergency Contact: _____
(Phone #) (Relationship)

Primary Physician: _____ Have you had previous Chiropractic Care? _____

INSURANCE

Do you have health Insurance? __ Yes __ No (we will take a copy of your insurance card for our records)

Who is the primary card Holder? _____ Date of Birth: _____

Is the patient covered by additional insurance? ___Yes ___ No Please list: _____

INJURY INFORMATION

Is this injury **Work** related? ___Yes ___No Is this injury **Auto** related? ___Yes ___ No

GOALS FOR CARE

People see the Chiropractor for a variety of different reasons. Some go for **relief of pain**, some to **correct the cause** and others for **prevention**. Your Doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

____ Relief Care – Symptomatic relief of pain or discomfort

____ Corrective Care – Correcting, relieving, stabilizing the cause of the problem

____ Prevention – Maintaining the body to the highest degree of health possible

____ I want the Doctor to select the type of care appropriate for my conditions.

List any other Doctors you have consulted for this condition: _____

_____

Patient Signature: _____ Date: _____

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CHIEF COMPLAINT

Name: _____ Date: _____

1. What is the reason for your consultation? Please list *ANY & ALL* of your health problems in order of importance. _____

_____

2. Since when have you had your main Problem? _____

3. How did your main problem start? ____ Gradually ____ Suddenly ____ Accident / Trauma ___ Do not know

4. Is your problem present: ___ 100% of the time ___ 50% of the time ___ less than 25% of the time
___ 75% of the time ___ 25% of the time

5. Is your problem getting?: ___ Better ___ Worse ___ Staying the same

6. Is your problem worse in the: ___ Morning ___ Afternoon ___ Evening ___ Night

7, Does your problem affect your: ___ Working ___ Sleeping ___ Recreation ___ Family ___ Daily routine.

8. Have you seen another health professional for your problem? ___ No ___Chiropractor ___ Medical ___ PT

9. Have you had your main problem before? ___Yes ___No

10. Indicate the severity of your main problem when at its worst.

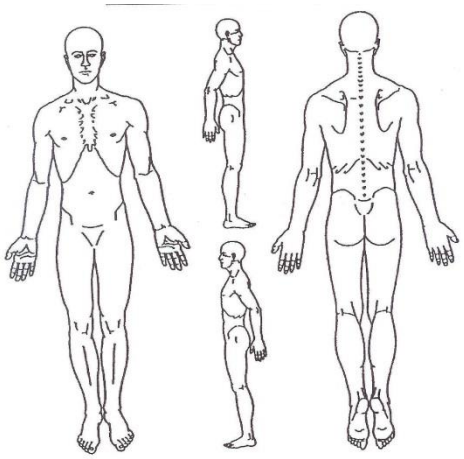
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

11. Indicate your level of commitment to correcting your problem?

(Not Committed) 0 1 2 3 4 5 6 7 8 9 10 (Very Committed)

12. Indicate on the body diagram ALL areas with ANY problems.

Please mark EVERYTHING no matter how small and even if it is not the reason for your consultation.



_____

CONSENT TO EVALUATE AND TREAT MINOR CHILD: I, being the patent or legal guardian of the aforementioned minor child (patient), give my permission to their evaluation, X-ray and Chiropractic Care.

Parent Signature: _____ Date_____

_____

Patient Signature: _____ Date _____

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HISTORY/SYMPTOMS

Name: _____ Date: _____

1. Father's Age _____ If deceased, what was the cause? _____

2. Mother's Age _____ If deceased, what was the cause? _____

3. Do you have brothers or sisters? ___Yes ___No

4. Do members of your family have: ___ Heart Problems ___ Diabetes ___ Other: _____
___ Cancer ___ Arthritis _____

5. Are you taking any medications? ___ No ___ Hormones ___ Anti-inflammatory ___ Thyroid
___ High Blood Pressure ___ Pain Killers ___ Diabetes Meds ___ Muscle Relaxants ___ Birth Control
___ Non-prescription

6. What is your work position: ___ Standing ___ Sitting ___ Moving

7. Do you usually sleep on your: ___ Back ___ Side ___ Stomach

8. How many hours do you sleep at night? ___ 4 hrs. or less ___ 5-6 hrs. ___ 7-8 hrs.
___ 8-10 hrs. ___ 10-11 hrs. ___ 12 hrs. or more

9. Do you consume and if yes, how many:

Tobacco / Cigarettes	___Yes ___ No	_____
Alcohol	___Yes ___ No	_____
Coffee / Tea	___Yes ___ No	_____
Vitamins / Supplements	___Yes ___ No	_____

10. Do you Exercise? ___Yes ___ No _____

11. Have you had or do you have any of the following problems?

___ Allergies	___ Anxiety	___ Arthritis	___ Sinusitis
___ Low Blood Pressure	___ Constipation	___ Convulsions	___ Itching
___ Diabetes	___ Urinate at night	___ Numbness	___ High Blood Pressure
___ Urinary Problems	___ Insomnia	___ Irritability	___ Hereditary disease
___ Meningitis	___ Edema (swelling)	___ Easily bruised	___ Kidney Stones
___ Hearing Problems	___ Hormonal Problems	___ Psychological Problems	___ Kidney Problems
___ Varicose Vein Problems	___ Nose Bleeds	___ Blood in Stool	___ Blood in Urine
___ Epilepsy	___ Skin Eruption	___ Dizziness	___ Circulation Problem
___ Fatigue	___ Sexual Problems	___ Cancer	___ Operations / Surgery
___ Shivers	___ Prostate Problems	___ Back Pain	___ Diarrhea
___ Heart Problems	___ Cold Extremities	___ Eye Problems	___ Fractures
___ Loss of Consciousness	___ Frequent Urination	___ Respiratory Problem	___ Hypoglycemia
___ Headaches	___ Depression	___ Shaking	___ Foot Problems
___ Abdominal Gas	___ Weight Loss		

Patient Signature: _____ Date: _____

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INITIAL NERVE SYSTEM PROFILE

Name: _____ Date: _____

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: ___ Front Impact ___ Side Impact ___Rear Impact _____

Was treatment received? Please describe: _____

When was your most recent strain/ stress at work? _____

Please describe the manner of the injury? _____

Was treatment received? Please describe? _____

Does your job require you remain in long term stressful postures? _____

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis

Golf, track and field _____

Trauma as a child! Fall on your head, impact to your head, concussion, fall onto your back or tailbone,

Biking accident _____

Work around the house – lifting, bending, woke-up with stiff neck, "back went out".

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y /N) Values? _____

Have you tested with high blood pressure? (Y / N) How many days per week do you skip one meal? (0 1 2 3 4+)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N) _____

Do you eat breakfast daily from Monday to Friday? (Y / N)_____

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly: _____

INITIAL FITNESS PROFILE

How many times per week do you exercise? Cardio___ Hrs.___ Days/wk. Weight training ___ Hrs. ___ Days/wk.

Low Impact (Yoga, etc.) ____ Hrs.____ Days/wk. What is your target weight? _____ Current weight? _____

How willing are you to change any of these things to reach your health goals? *(scale of 1-10)* _____

Patient Signature: _____ Date: _____

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INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night? (Y / N)

Do you average less than 7 hours of sleep per night? (Y / N)

Do you ever take pills to go to sleep or relax? (Y / N) What? _____

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Eagle Chiropractic PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____ Witness Initials

Patient or Authorized person's Signature Date

REGARDING: X-rays/ Imaging Studies

FEMALES ONLY *– please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

___ The first day of my last menstrual cycle was on ____/____/____ Date ___ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ _____ Witness Initials

Patient or Authorized person's Signature Date

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OFFICE POLICY

It is my responsibility to inform this office of any changes in my health status, insurance or my contact information.

INSURANCE: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. All professional services rendered are charged directly to the patient (me) and are my responsibility. We require that your examination day and first adjustment charges be paid in full when services are rendered and until insurance coverage has been verified. If your yearly deductible has not been met, if any services are denied or non-covered, if your coverage becomes inactive or you have met the maximum benefit fees for services will be your responsibility. In the even that your insurance check is mailed to you we expect you to present it to this office if there are charges owed.

CASH: Fees are paid at the time of service, unless special arrangements have been made in advance. If special arrangements are made and you become inactive by discontinuing your care, your entire unpaid balance will be due immediately and may be charged in full to the credit or debit card on file if other arrangements are not made. This applies to all plan types except Auto Injury and Work injury claims.

WORKMAN'S COMPENSATION: Report your accident to your employer, bring in the necessary insurance information, and complete and sign the appropriate forms for billing by the second visit. We will bill your insurance directly. In the event you receive the insurance check, we expect you will present the check to our office.

AUTO INJURY: Please provide us with the accident report, your car insurance, health insurance, liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. All charges are ultimately the responsibility of the patient or guardian in the event insurance doesn't pay. If you receive the insurance check, we expect you will present the check to our office.

***Any treatment remaining unpaid after (60) days will bear interest at the highest legal annual rate of interest allowed in Idaho until paid. If the office has to hire an attorney, collection agency or use outside means of collecting past due bills, you must reimburse the office for any attorney fees, court costs or collections spent in collecting the bill.

AUTHORIZATION OT RELEASE INFORMATION

I authorize you to release any information deemed appropriate to any insurance company, attorney or adjuster in order to process my claims for reimbursement, and I release you of any consequence thereof. We may disclose your personal health information (PHI) to family members or close friends whom accompany you if we determine it's in your best interest so we may provide you with the best care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care. You have the right to request a restriction in how we use your or disclose your PHI.

PRIVACY PRACTICES

I have received or reviewed the privacy practice notice for EAGLE CHIROPRACTIC PC and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Initial Intake Paperwork) on my first visit, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

TERMS OF ACCEPTANCE

We DO NOT diagnosis conditions or diseases, other than vertebral subluxations.
We offer NO treatment of conditions or disease, other than vertebral subluxations.
We promise NO cure from any condition or disease.

OUR GOAL

To locate, analyze, and correct spinal interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION is a detriment to life and health. Correction of the subluxation through specific chiropractic adjustment, allows the body to function at its optimal level. This allows innate healing power of the body to work at maximum efficiency to restore, maintain and promote natural healing.

I _____ have read the above statement and completely understand it. I do undertake chiropractic health care on this basis.

Patient Signature: _____ Date: _____