New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name_____ Date_____ Email_____

Your email will NOT be shared with any 3rd parties and is used for general office announcements

Mailing Address

Address_____ City_____ State_____ Zip_____
Cell_____ Work_____ Home_____ Referred By_____
Age_____ Birth date _____ Social Security #_____ # of Children_____
Occupation_____ Employer_____
Marital Status_____ Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Health Status_____
Emergency Contact_____ Phone_____

Current Complaints

Nature of Injury: Automobile_____ Work_____ Other_____
Please describe current complaints_____
_____

Severity of pain on your ***WORST*** day: LEAST WORST

1 2 3 4 5 6 7 8 9 10

Date of Injury_____ Date Symptoms appeared_____
Have you ever had same condition? Yes_____ No_____ If yes, when? _____
List other practitioners seen for this injury/condition_____
Have you ever been under chiropractic care? Yes_____ No_____ If yes, please describe_____
_____

Insurance Information

Name of party responsible for payment_____ Phone_____
Company Name_____ Do you have health insurance? Yes_____ No____
*If an auto accident please provide:
Insurance Company name_____ Contact Person_____
Phone_____ Claim #_____

Billing Address

Name of the Insured_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____ Date_____
Spouse's or Guardian's Signature_____ Date_____

Chiropractic Physicians
Dr. Michael Staub D.C., F.I.A.M.A. and Dr. Shaun Hudson D.C.
The Bone and Joint Wellness Center
10752 N 89th Pl, Suite A-101
Scottsdale, AZ 85260

Medical History

Have you been treated for any conditions in the last year? Yes_____ No_____

If yes, Please describe_____

Date of last physical exam_____ Is there a chance that you are pregnant? Yes_____ No_____

Have you had x-rays taken? Yes_____ No_____ If yes, where? _____

What medications are you taking and for what conditions? (Please list dosage and amounts, etc.)_____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency)_____

_____

Have you ever:	Yes	No	Briefly explain
Broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

Family History

Family Member	Present and past health conditions (Ex. Heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your condition?

_____

_____

_____

_____

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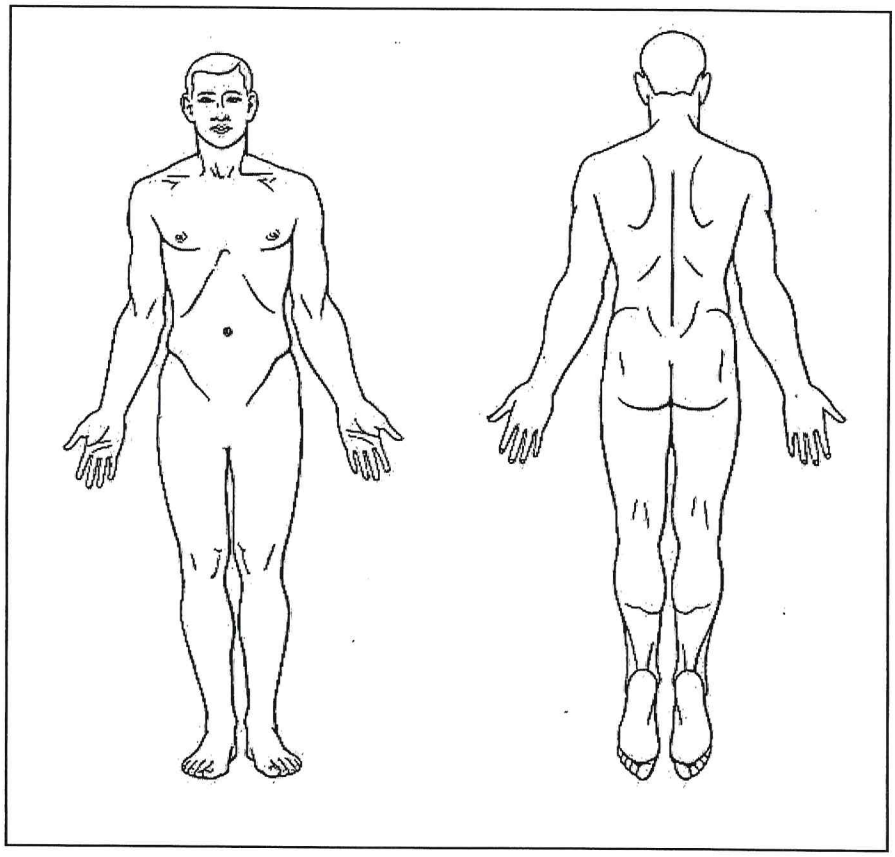
Have you suffered from any of the following in the past 6 months:

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma/Bronchitis ☐
- Back Pain ☐
- Breast Lump ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold Extremities ☐
- Diabetes ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of Balance ☐
- Neck Pain/Stiffness ☐
- Pacemaker ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of Breath ☐
- Sleep problems/Insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of Ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing



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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

At The Bone & Joint Chiropractic Clinic we are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment, or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released our health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

I have read your consent policy and agree to terms. I am also acknowledging that I have received a copy of this notice.

Print Name	Signature	Date

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P: (480) 990-2663 • F: (480) 941-2825

Terms of Acceptance

When a patient seeks Chiropractic healthcare and we accept patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis, or treatment for for those findings, we will recommend that you seek the services of healthcare provider.

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 complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Pregnancy Release:

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 perform an x-ray evaluation, I have been advised that x-ray can be hazardous to an unborn child.

Date of my last menstrual period _____

_____ _____

Signature Date

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Terms for Collections

I _____ understand that I am responsible for all fees and charges that I accumulate during treatment. This amount includes co-pays, co-insurance and/or deductibles, along with our cash rates for non-insured patients. The office will notify you of any amounts that you the patient are responsible for. Failure to contact the office for payment after the due date on the statement can result in your account being sent to collections. Once this occurs your account can be charged up to a 50% surcharge. If you have any questions, please ask either the front office staff or your treating physician.

_____

Patient Signature

_____

Date

_____

Witness Signature

_____

Date

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No-Show and Late Cancellation Policy

Dear Valued Patients,

Please be advised there is a $45.00 fee for appointment cancellations without 24 hours notice of your appointment time.

It is very important that you keep your scheduled appointment with us as your healing is dependent upon it. As a courtesy, The Bone & Joint Wellness Center provides reminder calls and text messages.

If your schedule changes and you cannot keep your appointment, please contact us with 24 hours notice so we may reschedule you and accommodate those patients who are waiting for an appointment. This no-show charge is not reimbursable by your insurance company. You will be billed directly for it.

I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a no-show charge.

_____ _____

Name Date

I authorize _____ to keep my signature on file and to charge my account for my missed appointment.

Cardholder Name_____

Billing Address_____

City_____State____Zip_____

Account Number_____

Exp.____/____ CV_____

Signature_____

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Consent for the Treatment of a Minor

I, _____, hereby authorize

Dr. _____, and whomsoever he may designate as his assistants, to administer treatment as he determines is necessary to my son/daughter, _____.

I further authorize these treatments if I choose to send my son/daughter for their treatments unaccompanied by a parent/guardian.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

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