DEYOUNG CHIROPRACTIC

Patient Acct _____

Legal Name _____ DoB _____ Age _____ Today's Date _____

Nickname _____ Phone Number _____ Cell Carrier _____

Email Address _____ Preferred Method of Contact: ☐Call ☐Text ☐Email

Street _____ City _____ Zip Code _____

SSN _____ Marital Status ☐M ☐S ☐D ☐W Hobbies/Interests _____

Occupation _____ Employer _____ ☐FT ☐PT ☐Retired ☐N/A

Number of Children and ages _____ Name of Spouse/Partner _____

Emergency Contact _____ Phone Number _____

Previous Chiropractic Care ☐Y ☐N If yes, explain _____

Current Height _____ Current Weight _____ Previous Surgery _____

Current Medications _____

Current Vitamins _____

How did you hear about our office? _____

*ABOUT YOUR HEALTH: The human body is designed to be healthy. Throughout life, trauma can occur which interes with your full health expresion. This case history will uncover the layers of damage to your spine and nervous system. Following your exam, we will outline a course of care to correct these layers of damage to recover your inborn health potential.*

**LOSS OF WELLNESS**

*1. Your Own Birth Process*

☐Y ☐N Was the delivery long? _____
☐Y ☐N Was the delivery difficult? _____
☐Y ☐N Forceps? _____
☐Y ☐N Breech / Cephalic? _____
☐Y ☐N Home Birth? _____
☐Y ☐N Hospital Birth? _____
☐Y ☐N Mother given drugs during delivery? _____
☐Y ☐N Was labor induced? _____

*2. Growth & Development*

☐Y ☐N Were you taught to care for your spine? _____
☐Y ☐N Did you fall out of bed? _____
☐Y ☐N Were you breast fed? _____
☐Y ☐N Did you have childhood sickness? _____
☐Y ☐N Did you have childhood accidents? _____
☐Y ☐N Did you have surgery during childhood? _____
☐Y ☐N Did you take medicine during childhood? _____
☐Y ☐N Were you spanked or yanked as a child? _____
☐Y ☐N Were you physically abused? _____
☐Y ☐N Did you have any sports injuries as a child? _____
☐Y ☐N Were you a gymnast/cheerleader? _____
☐Y ☐N Other Traumas? _____

*3. Current Health Habits*

☐Y ☐N Did you or do you smoke? _____
☐Y ☐N Did you or do you drink alcohol? _____
☐Y ☐N Diet - Do you eat healthy foods? _____
☐Y ☐N Do you have problems sleeping? _____
☐Y ☐N Do you have any mental stress? _____
☐Y ☐N Do you have any physical stress? _____
☐Y ☐N Do you exercise? _____
☐Y ☐N Do you use a computer/tablet/phone? Duration? _____
☐Y ☐N Have you been in any car accidents? How many and when? _____
☐Y ☐N Have you had any sports injuries? _____
☐Y ☐N Other traumas? _____

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Currently Pregnant: ☐Y ☐N ☐Unsure *If yes,* how many weeks? _____ Due Date: _____

**Symptoms and Poor Health (Present state of Health)**

Current health complaints/reasons for consulting our office: _____

_____

Date when problem started _____ Pains are ☐Achy ☐Dull ☐Sharp ☐Stabbing ☐Tingling and Numbness

Frequency of pain ☐Constant ☐ Come and go Is the condition worse during ☐AM ☐PM ☐Remain the same ☐_____

What aggravates your condition? _____

What lessens your condition? _____

Does your condition interfere with your daily activities such as:

☐Sleep ☐Work ☐Sitting ☐Standing ☐Walking ☐Dressing ☐Physical Activity ☐Lifting >10lbs ☐Household Chores ☐Hobbies

Have you seen other doctors for this condition? _____ Any home remedies? _____

Rate your pain based on 0 being NO PAIN and 10 being THE WORST PAIN:

Your pain right now _____ Your typical/average pain _____ Your pain at it's best _____ Your pain at it's worst _____

| **OTHER SYMPTOMS** | ☐NECK PAIN | ☐MID BACK PAIN | ☐LOW BACK PAIN |
|---|---|---|---|
| ☐ADD/ ADHD | ☐Vision Problems | ☐Gallbladder Conditions | ☐Menstrual Issues |
| ☐Anxiety | ☐Fatigue/ Trouble Sleeping | ☐Stomach Problems | ☐Reproductive Issues |
| ☐Depression | ☐Frequent Colds | ☐Ulcers | ☐Infertility |
| ☐Irritability | ☐Hearing Problems | ☐Gastritis | ☐Leg Numbness ☐R ☐L |
| ☐Nervousness | ☐Hand/Finger Numbness | ☐Kidney Problems | ☐Knee Pain ☐R ☐L |
| ☐Difficulty Concentrating | ☐Radiating Arm Pain ☐R ☐L | ☐Indigestion | ☐Hip Pain ☐R ☐L |
| ☐Dizziness | ☐Shoulder Pain ☐R ☐L | ☐Constipation | ☐Rib Pain |
| ☐Vertigo | ☐High Blood Pressure | ☐Colitis/Crohns | ☐Scoliosis |
| ☐Ringing in Ears | ☐Heart Condition | ☐Diarrhea | ☐Carpal Tunnel |
| ☐Asthma | ☐Difficulty Breathing | ☐Gas Pain | ☐Thyroid Condition |
| ☐Sinus Problems | ☐Congestion | ☐Irritable Bowel / IBS | ☐Cancer _____ |
| ☐Allergies | ☐Bronchitis / Pneumonia | ☐Bladder Issues | ☐Other _____ |

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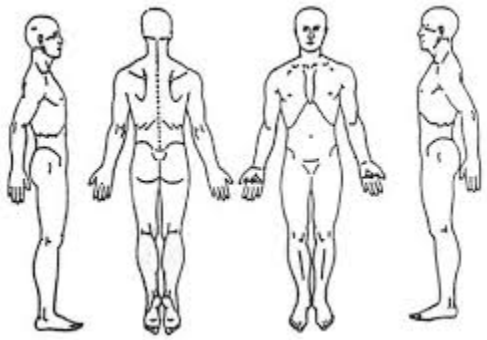
**Use the diagram to circle where you are experiencing pain or discomfort :**



**FAMILY HISTORY**

☐Heart Disease / Attack - Relation _____

☐Osteo / Rheumatoid Arthritis - Relation _____

☐Diabetes I / II - Relation _____

☐Cancer / Tumor - Relation _____

☐Other _____ Relation _____

**What prompted you to seek care? What is your goal?**

☐Reduce symptoms / pain

☐Improve range of motion

☐Pain management

☐Prevent injury during exercise

☐Wellness

☐Improve body function

☐Find a solution to the ongoing issues

☐Return to regular activities/hobbies like _____

**Please check the options that apply to you:**

☐I am only interested in short-term symptom relief care.

☐I am interested in symptom relief care & corrective care to maintain spinal stability & optimal nerve function

☐I feel good. I want to include chiropractic care into my wellness regimen so I can stay active for life.

☐I would like to schedule an appointment for my family members for a spinal check to ensure proper growth and development throughout all stages of life.

The above information is true and accurate to the best of my knowledge.

Signature of Patient _____ Date _____

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# NOTICE OF HIPAA PRIVACY PRACTICES AND OFFICE POLICIES

- We will not disclose your health information without your written authorization as stated within the HIPAA guidelines.
- It is your responsibility to inform DeYoung Chiropractic of any changes to your contact information.
- It is your responsibility to inform us with any changes to your symptoms, health, and/or new injuries.
- **Cancellation/No-Show Appointments:** Please provide **24 hour** notice when canceling or rescheduling your appointment. This allows us time to offer your appointment slot to another patient in need of care. Late cancellations or missed appointments may result in a **$30 fee.**
- **Massage Appointments:** Massages are scheduled by appointment only and require a **24 hour** cancellation notice. Cancellations within 24 hours or no-show appointments will be **subject to a $30 fee.** Late arrivals may result in a shortened length of the scheduled service.

## FINANCIAL RESPONSIBILITIES

**PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS ARRANGEMENTS ARE MADE WITH OUR OFFICE**

*Would you like DeYoung Chiropractic to bill health insurance for any services rendered?*

☐ YES

☐ NO

- It is your responsibility to inform DeYoung Chiropractic of changes to your billing information and health insurance.
- It is your responsibility to contact your insurance company for chiropractic coverage and eligibility. DeYoung Chiropractic may provide an estimated cost of services. Benefits are not a guarantee of coverage in full and it is the patient's financial responsibility to cover any non-covered charges.

## MEDICARE ENROLLEES

**Are you Insured through Medicare?**

☐ YES

☐ NO

- You MUST inform DeYoung Chiropractic if you are a Medicare Recipient. If you opt not to bill Medicare, we are required to document your decision on the **Advanced Beneficiary Notice (ABN)** Form.
  **MEDICARE ENROLLEES:** Medicare may only cover spinal manipulation when performed on your initial visit of complaint and during a recommended care plan. Medicare may not cover initial examination, xrays, physical therapy, and mechanical traction. DeYoung Chiropractic can bill these services to any participating secondary insurance if applicable.

## RADIOLOGY CONSENT

- This form authorizes the use of diagnostic x-ray examination in which DeYoung Chiropractic may consider necessary or advisable during the course of my examination, treatment, and chiropractic care.

**Are you currently or possibly Pregnant?**

☐ YES

☐ NO

**PREGNANCY VERIFICATION:** I will notify DeYoung Chiropractic if my pregnancy status changes. If it later becomes known that I am pregnant, I do not hold DeYoung Chiropractic, Dr. Aaron DeYoung, Dr. Gretchen DeYoung, Dr. Lauren Richards, or DeYoung Chiropractic staff liable.

DeYoung Chiropractic reserves the right to update or change the terms of this notice at any time. You have the right to obtain a paper copy of this notice from our office even if you have agreed to accept the notice electronically.

**By signing below, I am acknowledging that I understand and agree to the above terms and policies. I hereby authorize the doctor(s) to examine, treat, and render care at Deyoung Chiropractic.**

**Patient Legal Name (Please Print):_____ Date of Birth:_____**

**Patient/Guardian Signature:_____ Today's Date: _____**

**Parent/Guardian Name Printed: _____**

**Relationship: _____**

*Revised December 2022*