COMPASS
CHIROPRACTIC

At our office, we have one simple goal. We want to change your life by rendering the highest quality chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your God given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions, please feel free to ask us.

1. **Your Initial Examination:** In your first visit, you will have an initial consultation with the doctor. This is usually preceded by a chiropractic examination including nerve systems scans and spinal x-rays if warranted and appropriate. Your first Chiropractic adjustment is included in this visit.
2. **Your Report of Findings and Care Plan:** On your second visit to our office, the doctor will discuss your scans and x-rays with you to establish a schedule of visits to address your main complaint. Once the outward signs of this problem have been addressed, the obvious question is, "Would you be willing to take the additional steps that would be necessary to strengthen and stabilize your health so that the problem that caused you to consult us would be far less likely to return?" Our long-term goal is to help you navigate life's stress and strain on your nervous system and to maintain the health gains achieved through your initial phase of care. We call this wellness care in our office. These visits are less frequent than the acute phase and focus on prevention. Our wellness care patients consult with us regularly about which lifestyle strategies could be employed to cause their health to improve year after year.

Please print clearly and fill in completely

Print Name _____ **Email** _____

Street Address _____ **Home Phone**_____

City _____**State**____ **Zip** _____ **Cell Phone** _____

Age_____ **Date of Birth**_____**Weight**_____**Height**_____

Spouse Name/Emergency Contact_____ **Phone** _____

Marital Status __**S** __**M** __**W** __**D** **Number of Children**_____

Health History

Give reason for seeking chiropractic care: _____

Additional details about this issue:_____

Describe any other health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications:_____

List any past surgeries & dates:_____

List any x-rays you've had in the past 2 years: _____

Personal & Family History

Your Occupation _____ Work Duties_____

Any significant falls or accidents, not necessarily causing pain? Please list:

1._____Date:_____

2._____Date:_____

3._____Date:_____

Early Trauma

Were you born at home or in the hospital _____? Were drugs used during delivery? Yes____No____
Were Forceps/Force used? Yes____ No____ Drugs taken during pregnancy_____?

Fall/Jump from a height of < 3 feet	__Yes __No	Inhaler Use	__Yes __No
Car Accident	__Yes __No	Surgery	__Yes __No
Childhood Illness	__Yes __No	Youth Sports	__Yes __No
Repeated Prolonged Antibiotics	__Yes __No	Vaccination	__Yes __No

Any significant falls or accidents as a child, not necessarily causing pain? Please list:

1._____Date:_____

2._____Date:_____

Chiropractic History

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes, Doctor's Name_____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays_____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ If yes why? _____

Rate Your Overall Health

Our goal is to help you achieve and maintain optimal health. To better help you with this we need to understand how you view your overall health. Please **circle** what you consider to be your current level of health.

10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Referrals

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know who referred you, ***or*** where you heard about our office? _____

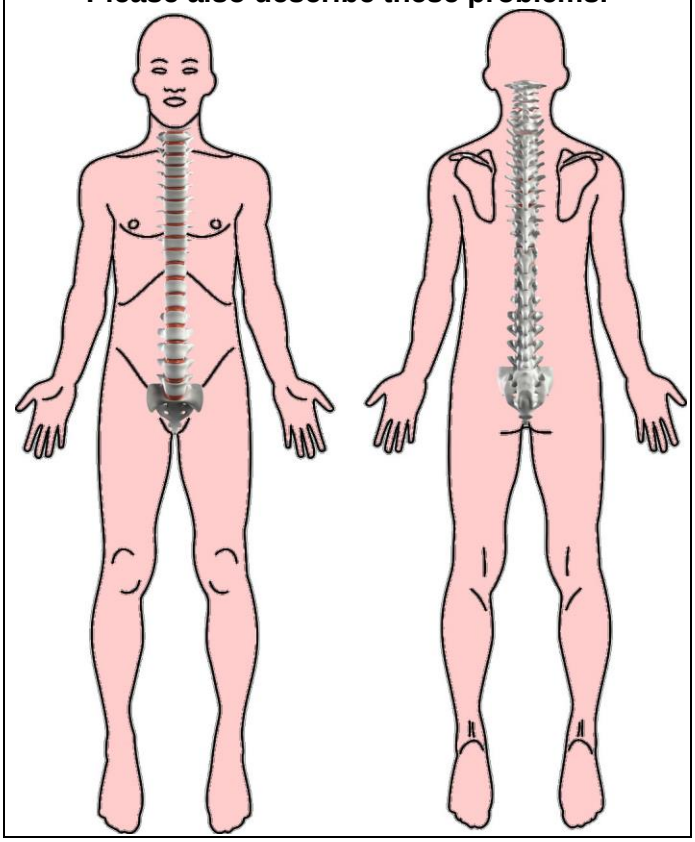
FEMALES ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes ❑** **No ❑**

Please Fill in Below

If you currently, or have recently, suffered from the following, *please check if YES* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg / Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Joint Pain / Swelling	❑	❑
Numbness	❑	❑
Frequent Colds	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Anxiety / Depression	❑	❑
Sleep Disorders	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Female Issues	❑	❑
Cancer	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Osteoporosis	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other: Write in:	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



When did your main health concern start?

_____

Have you had this condition before? ☐ Y ☐ N

If yes, what ***originally*** started this condition?

_____

If you have pain associated with your condition, how would you describe it? Check all that apply.

☐ Sharp ☐ Constant ☐ Localized ☐ Radiating
☐ Pins & Needles ☐ Dull ☐ Numbness
☐ Burning ☐ Comes & Goes

Is there any time of the day or any activity that makes your condition worse?

_____

Better?

_____

Any other concerns or health information you feel we may need to be aware of for your care?

_____

Privacy and Informed Consent

Notice of Open Adjusting Policy

I consent to initiate care in the form of an examination, nerve scans, and, if needed, x-rays at Compass Chiropractic. This office provides care in an "open-door/open adjusting" environment. This involves several patients being seen in the same adjusting room at the same time. This format is for routine care, NOT for patient histories or exams. These procedures are completed in a private, confidential setting. Your signature below constitutes authorization for "incidental disclosure" of health information that could occur in this format. This is intended to make our office more efficient and enhances your access to quality health care. If you have any concerns, other arrangements can be made.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name _____ **Date**_____

Sign your name_____