THREE NOTCH CHIROPRACTIC
Promoting Personal & Community Wellness

Thank you for choosing Three Notch Chiropractic to assist you in achieving your Health Rehabilitation / Wellness goals. If you have any questions about this form, please do not hesitate to ask us for assistance. The accuracy of your information is vital *and* we are glad to help!

Three Notch Chiropractic, PLLC
504 E Three Notch St
Andalusia, AL 36420

800.372.1391

www.threenotchchiropractic.com
www.fhacorp.com

Personal Information

Date _____ File# _____

Full Name: _____ Preferred Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment / Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___ Age: ____ Social Security Number: ___-___-___

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ M ☐ F

Email Addr: _____

Are you a full-time student? ☐ Yes ☐ No How did you hear about us: _____

Occupation: _____ Occupational Duties: _____

In Case of Emergency: Contact: _____ Rel: _____ Ph: _____

Policy Holder / Guarantor Information

Full Name: _____ *Jr / Sr*
Last *First* *M.I.*

Address: _____
Street Address *Apartment / Unit #*

_____
City *State* *ZIP Code*

Birth Date: ___/___/___ Social Security Number: ___-___-___ Gender: ☐ M ☐ F

Consent for Electronic Communications

Three Notch Chiropractic will start sending text reminders for patients beginning January 1, 2014. Please provide us with your preferred mobile phone number where texts will reach you most effectively.

I, _____, give my consent to Three Notch Chiropractic to contact me via the electronic communications below for appointment confirmations and appointment reminders sent 24 hours in advance, and regarding topics pertinent to patient health and condition.

Initials _____

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Diet and Exercise

Have you ever smoked cigars or cigarettes? ☐ Yes ☐ No Do you still smoke? ☐ Yes ☐ No

How much do you smoke? ☐ Less than 1 pack per week ☐ 1-2 packs per week ☐ 1 packs every 2 weeks
☐ 1 pack per day ☐ More than 1 pack per day

Do you drink alcoholic beverages? ☐ Yes ☐ No How many alcoholic beverages do consume a per week? _____

Have you ever been diagnosed by a physician as an alcoholic? ☐ Yes ☐ No

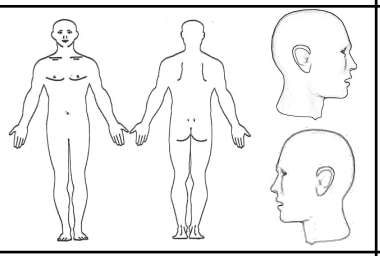
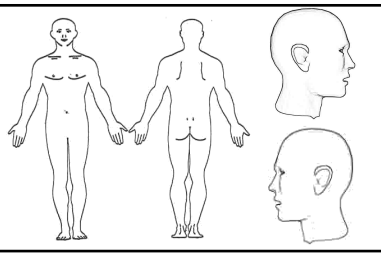
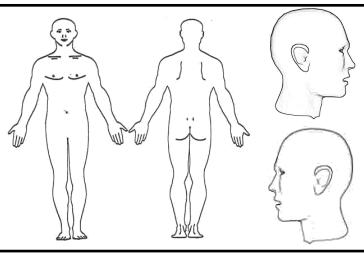
Have you ever been diagnosed by a physician with any liver-related problems? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No How many days a week do you exercise? _____

Patient Name _____Date _____ File #_____

Chief Complaint

The reason for this visit is a result of: Work Sports Auto Trauma Chronic Are You/Will You Litigate Y N

	Chief Complaint	**Complaint 2**	**Complaint 3**
Today's Complaint:	_____	_____	_____
When did these begin:	Suddenly: ___/__/___ Gradually	Suddenly: ___/___/___ Gradually	Suddenly: ___/___/___ Gradually
***Explain what happened*:**	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Has this happened in the past? Y N ***(If Yes then explain)***	_____ _____ _____	_____ _____ _____	_____ _____ _____
What do you do/take that makes the condition BETTER?	_____ _____ _____	_____ _____ _____	_____ _____ _____
What do you do/take that makes the condition WORSE?	_____ _____ _____	_____ _____ _____	_____ _____ _____
Where specifically is the problem located? ***(Circle the area)***			
What words best describes your discomfort? ***(Check all that apply)***	Sharp Dull Shooting Throbbing Tingling Cramping Aching Burning Stiffness Numbness Constant Comes/Goes Worse in AM Worse in PM Awakens me Worsening Improving Stays Same Other	Sharp Dull Shooting Throbbing Tingling Cramping Aching Burning Stiffness Numbness Constant Comes/Goes Worse in AM Worse in PM Awakens me Worsening Improving Stays Same Other _____	Sharp Dull Shooting Throbbing Tingling Cramping Aching Burning Stiffness Numbness Constant Comes/Goes Worse in AM Worse in PM Awakens me Worsening Improving Stays Same Other _____
Rate the severity of your pain: ***(Circle one for EACH)***	Today: 1 2 3 4 5 6 7 8 9 10 (*no pain)→(severe pain*) At Worst: 1 2 3 4 5 6 7 8 9 10 At Best: 1 2 3 4 5 6 7 8 9 10 On Avg: 1 2 3 4 5 6 7 8 9 10	Today: 1 2 3 4 5 6 7 8 9 10 At Worst: 1 2 3 4 5 6 7 8 9 10 At Best: 1 2 3 4 5 6 7 8 9 10 On Avg: 1 2 3 4 5 6 7 8 9 10	Today: 1 2 3 4 5 6 7 8 9 10 At Worst: 1 2 3 4 5 6 7 8 9 10 At Best: 1 2 3 4 5 6 7 8 9 10 On Avg: 1 2 3 4 5 6 7 8 9 10
What activities are limited by your Chief Complaint?: ***(Check all that apply)***	Bending Getting Up Reading Turning Head Coughing Lifting Sitting Urination Daily Routine Lying Down Sleeping Walking Driving Pulling Sneezing Working Bowel Movements Pushing Standing Other _____		
What treatments have you already received for your *Chief Complaint?*	Date / Dr. / City/ST / What was done? Chiropractic _____ Acupuncture _____ Massage _____ Phys Therapy _____ Medication _____ Surgery _____ Pain Mgmt		

Patient Name _____Date _____ File #_____

Vitamins, Minerals, Herbs, or Supplements

Name	Dosage	Frequency	For What Condition	Prescribed by:
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		

Over-the-Counter Medications

Name	Dosage	Frequency	For What Condition	Prescribed by:
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		

Prescription Medications

Name	Dosage	Frequency	For What Condition	Prescribed by:
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		
		____ *times per Dy Wk Mo*		

Recent Physicians

Please list all current Physicians: None

Physician Name	Type of Physician	Location	For What Condition?	Phone

Surgeries

Please list all Surgeries / Hospitalizations / Infections: None

DATE	Dr.	Condition	Procedure	Outcome	Residual Pain?

Accidents and Concussions

Please list all auto accidents and concussions: None

DATE	DETAILS *(ie accidents: On what side were you hit? How fast? Did you go to the hospital? What was done for you?, etc.)*

Patient Name _____Date _____ File #_____

Your Health History

Check if you have ever been diagnosed by a physician with any of the following … (Check one or more)

Allergies

Airborne Allergies: □ No
- □ Animal
- □ Mold / Fungus
- □ Pollens
- □ Cat Hair
- □ Cockroach
- □ Dog Hair
- □ Feather Mix
- □ Guinea Pig Hair
- □ Dust Mites
- □ Other: _____

Chemical Allergies: □ No
- □ Acetone
- □ Acetylcholine
- □ Auto Exhaust
- □ Benzyl Alchohol
- □ Chlorine
- □ Citric Acid
- □ Cologne (all)
- □ Diesel Exhaust
- □ Dopomine
- □ Estradiol
- □ Ethanol
- □ Fluorine
- □ Formaldehyde
- □ Latex
- □ Melatonine
- □ Newspaper Print
- □ Norepinephrine
- □ Progesterone
- □ Propylene
- □ Serotonin
- □ Silicone Implant
- □ Sponge Rubber
- □ Toluene
- □ Trichloroethylene
- □ Wood Pulp
- □ Xylene
- □ Other: _____

Drug Allergies: □ No
- □ Anticonvulsants
- □ Codeine
- □ Insulin Preparations
- □ Iodine
- □ Morphine
- □ Novocain
- □ Penicillin
- □ Sulfa
- □ Other: _____

Food Allergies: □ No
- □ Artificial Colorings
- □ Artificial Flavorings
- □ Beef
- □ Coffee/Tea
- □ Dairy
- □ Eggs
- □ Fish/Shellfish
- □ Fruits
- □ Lamb
- □ Nuts
- □ Pork
- □ Vegatables
- □ Other: _____

Cardio-Pulmanary

- □ Anemia
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Hemorrhoids
- □ Lung Disorders
  - □ Acute Resp. Distr. Syn.
  - □ Alpha-1 Antitrypsin Deficiency
  - □ Asbestos / Dust Disease
  - □ Asthma
  - □ Bronchiectasis
  - □ Bronchitis (Chronic)
  - □ Bronchopulmanary Dysplasia
  - □ COPD
  - □ Cystic Fibrosis
  - □ Emphysema
  - □ Farmer's Lung
  - □ Hantavirus
  - □ Histoplasmosis
  - □ Legionellosis
  - □ Pleurisy
  - □ Pneumonia
  - □ Pneumothorax
  - □ Primary Alveolar Hypoventilation Syn
  - □ Pulmonary Alveolar Proteinosis
  - □ Pulmonary Embolus
  - □ Pulmonary Fibrosis
  - □ Respiratory Distress Syndrome
  - □ Respiratory Syncytial Virus
  - □ Sarcoidosis
  - □ Sev. Acute Resp. Syn
  - □ Spontaneous Pneumothorax
  - □ Tuberculosis
- □ Raynaud's Phenomenon

Endo, Gastro, Neuro

- □ Sickle Cell Anemia
- □ Sinus Infections (chronic)
- □ Wegener's Granulomatosis
- □ Other: _____
- □ Autoimmune Disorders
  - □ Dermatitis
  - □ Churg-Strauss
  - □ Eosinophilic Fasciltis
  - □ Dermatomyositis/ Polymyositis
  - □ Goodpasture's Syn
  - □ Interstitial Granuloma-tous Dermatitis
  - □ Lupus SLE
  - □ Lupus DLE
  - □ Lupus SCLE
  - □ Lupus Anticoagulant
  - □ Mixed Connective Tissue Disease
  - □ Relapsing Polychondritis
  - □ Rheumatoid Arthritis
  - □ Sarcoidosis
  - □ Scleradema
  - □ Sjogren's Syndrome
  - □ Skin Immunofluores-cence
  - □ Vasculitis
- □ Bladder Disease
- □ Candida
- □ Chicken Pox
- □ Chronic Fatigue Syn.
- □ Chrohn's Disease
- □ Diabetes
- □ Epilepsy
- □ Gall Bladder Problems
- □ Headaches
  - □ Cluster Headaches
  - □ Migraine Headaches
  - □ Sinus Headaches
  - □ Stress Headaches
  - □ Tension Headaches
- □ Incontinence
- □ Irritable Bowel Syndrome
- □ Kidney Disease
- □ Liver Disease
- □ Liver Problems
- □ Measles
- □ Mumps
- □ Seizures
- □ Shingles
- □ Stomach Ulcers
- □ Thyroid Dysfunction
- □ Urinary Tract Infection
- □ Other: _____

Emotional / Mental

- □ Anger Disorders
- □ Anxiety Disorders
- □ Aspergers Syndrome
- □ ADHD
- □ Autistic Disorder
- □ Avoidant Personality Dis.
- □ Bipolar Disorder
- □ Borderline Personality Disorder
- □ Capgras Syndrome
- □ Child Behavior Disorders
- □ Combat Disorders
- □ Cyclothymic Disorders
- □ Dependent Personality Disorder
- □ Depression
- □ Dissociative Disorders
- □ Mood Disorders
- □ Eating Disorders
- □ Firesetting Behavior
- □ Hypochondriasis
- □ Impulse Control Disorder
- □ Kleine-Levin Syndrome
- □ Kleptomania
- □ Multiple Personality Dis.
- □ Munchhousen Syn.
- □ Narcissistic Personalit
- □ Narcolepsy
- □ Obsessive Compulsive
- □ Phobic Disorders
- □ Psychotic Disorders
- □ Schizophrenia
- □ Seasonal Affective Dis.
- □ Sexual/Gender Disorders
- □ Sexual Dysfunctions
- □ Sleep Disorders
- □ Post-Traumatic Stress
- □ Substance Abuse
- □ Suicidal Tendencies
- □ Other: _____

Sensory

- □ Blindness
- □ Cataracts
- □ Cholesteatoma
- □ Deafness
- □ Hearing Loss
- □ Ear ringing
- □ Eczema
- □ Glaucoma
- □ Laryngitis (chronic)
- □ Macular Degeneration
- □ Mumps
- □ Meniere's Disease
- □ Nasal Polyps
- □ Perforated Eardrum
- □ Psoriasis
- □ Rhinitis
- □ Sinusitis
- □ Tinnitus
- □ Vertigo
- □ Other: _____

Musculoskeletal

- □ Arthritis
  - □ Ankylosing Spondylitis
  - □ Behets Disease
  - □ Carpal Tunnel Syn.
  - □ DISH
  - □ Ehlers-Danlos Syn.
  - □ Felty's Syndrome
  - □ Fibromyalgia
  - □ Infectious Arthritis
  - □ Mixed Conn. Tiss. Dis.
  - □ Osteoarthritis
  - □ Paget's Disease
  - □ Polymyalgia Rheumatic
  - □ Pseudogout
  - □ Psoriatic Arthritis
  - □ Repetitive Stress Injury
  - □ Reactive Arthritis
  - □ Rheumatoid Arthritis
  - □ Scleraderma
  - □ Sjogren's Syndrome
  - □ Stills Disease
- □ Gout
- □ Herniated Disk
- □ Lyme Disease
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Numb/Tingling in Feet
- □ Numb/Tingling in Hands
- □ Osteoporosis
- □ Parkinson's Disease
- □ Pinched Nerve
- □ Polio
- □ Rheumatism
- □ Sciatica
- □ TMJ
- □ Other: _____

Cancer

- □ Bladder
- □ Brain
- □ Breast
- □ Cervical
- □ Colon / Rectal
- □ Endometrial
- □ Eye
- □ Kidney
- □ Leukemia
- □ Lung
- □ Non-Hodgkin's Lymphoma

Cancer

- □ Ovarian
- □ Pancreatic
- □ Prostate
- □ Skin
  - □ Basal Cell
  - □ Squamous Cell
  - □ Melanoma
- □ Stomach
- □ Thyroid
- □ Uterine

Reproductive

- □ Have you given birth
- □ How many vaginally? ___
- □ How many C-section? __
- □ Chlamydia
- □ Dysplasia
- □ Erectile Dysfunction
- □ Genital Herpes
- □ Gonorreha
- □ HPV
- □ Impotency
- □ Syphilis
- □ Infertility
- □ Cystitis
- □ Menopause
- □ Prostate Enlargement
- □ Testicular Dysfunction
- □ Uterine Dysfunction
- □ Vaginal Yeast Infections (chronic)
- □ Other: _____

Your Family History

(M) Mother
(F) Father
(S) Sibling
(MG) Maternal Grandparent
(PG) Paternal Grandparent

Cancer:
- □ Bladder ____
- □ Brain ____
- □ Breast ____
- □ Cervical ____
- □ Colon / Rectal ____
- □ Endometrial ____
- □ Eye ____
- □ Kidney ____
- □ Leukemia ____
- □ Lung ____
- □ Non-Hodgkin's Lymphoma ____
- □ Ovarian ____
- □ Pancreatic ____
- □ Prostate ____
- □ Skin ____
  - □ Basal Cell ____
  - □ Squamous Cell____
  - □ Melanoma ____
- □ Stomach ____
- □ Thyroid ____
- □ Uterine ____

Cardio-Pulmonary:
- □ Anemia ____
- □ High Blood Press____
- □ Low Blood Press____
- □ Stroke ____
- □ Other: _____

Patient Name _____Date _____ File #_____

Authorizations & Releases

Three Notch Chiropractic, PLLC
504 E Three Notch St Andalusia, AL 36420

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein, for the child to sign their self in for treatment, and be treated without my presence on the 4th and following visits . The patient may refuse treatment at any time.

Initials _____ Parent, Guardian, Patient's Legal Representative_____ Begin Date_____ End Date_____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this offices. The patient agrees to any additional fees associated with this services and assigns benefits to be paid directly to that provisional by your third-party payor.

Initials _____

Consent to Perform and Interpret X-rays (Regarding Pregnancy)

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.

Initials _____ First day of last menstrual period: __/__/__ Hysterectomy/Tubal Ligation? N / Y __/__/__

This is to certify that, to the best of my knowledge, I **am** ___ weeks pregnant and have been advised that x-ray can be hazardous to an unborn child. I therefore accept chiropractic care **without** an X-ray evaluation and assume any associated risks.

Initials _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patients rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available at: http://www.cms.hhs.gov/SecurityStandared/downlowads/securityproposedrule.pdf and as a pamphlet in our front lobby.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, heath care operations and coordination of care. The patients agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has their right to examine and obtain a copy of their health records at any time and request corrections. The patient may re quest to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to these restrictions.
3. The patients written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting you PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy.
5. Patients have right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy

Initials _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initials _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for the services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments cancelled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligations and appointment polity to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by the patient to the practice for current and future charges, when incurred.

Initials _____

Acknowledgement of Non-Medicare/Medicaid Status and Obligation

The patient hereby acknowledges Three Notch Chiropractic, PLLC is **not** a Medicare/Medicaid provider and does **not** provide services for such primary, secondary and or tertiary recipients. Patient acknowledges personal obligation to notify Three Notch Chiropractic, PLLC in the effect of changes their to Medicare/Medicaid status and make personal arrangements for seeking a licensed provider of the Medicare/Medicaid system. Patient acknowledges all treatments performed by Three Notch Chiropractic while patient is an active Medicare/Medicaid recipient, whether Medicare/Medicaid status changed knowingly or unknowingly, is due to failure by patient to make proper notification. Patient therefore accepts full responsibility and indemnifies Three Notch Chiropractic for any and all losses and liabilities. **Initials** _____