reset get back to great rethinkchiropractic rethinkmassage

MEMBER HEALTH HISTORY

In order to provide you the best possible service, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

Member Data

First Name_____ M.I._____ Last Name_____ ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Telephone (home)_____ (work)_____ (cell)_____

Age_____ Birth Date_____ Email _____

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name_____ # of Children_____

Occupation_____ How did you hear about us?_____

Previous Chiropractic Care? ☐ Yes ☐ No Date of last adjustment _____

Previous Massage Therapy? ☐ Yes ☐ No Date of last massage_____

Emergency Contact_____Phone #_____Relationship_____

Purpose of this visit

What would you like to improve? _____

What symptoms have you had? _____

Describe (circle) Sharp Dull Achy Tension Throbbing Tingling

How long have you dealt with this? _____

Does it travel or radiate to another area? ☐ Yes ☐ No

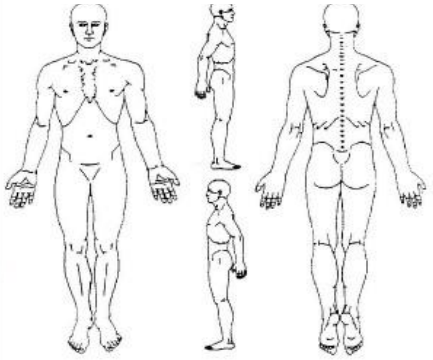
Intensity of your pain / tension: (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

I feel better when I…_____

I feel worse when I…_____

Have you ever experienced this problem before? ☐ Yes ☐ No

Please indicate areas of stress, tension or pain.



Comments_____

_____

Past History

Have you ever had any surgery? ☐ Yes ☐ No Please state: _____

Have you ever had any car accidents? ☐ Yes ☐ No Please state:_____

Sports injuries, falls, broken bones? ☐ Yes ☐ No Please state:_____

Do you have the following health conditions? Check all that apply: ☐ Cardiac/circulatory problems ☐ High blood pressure

☐ Epilepsy ☐ Diabetes ☐ Frequent headaches ☐ Arthritis ☐ Allergies ☐ Osteoporosis ☐ Varicose veins

Any medications? _____

Women only: Are you pregnant? ☐ Yes ☐ No Number of weeks:_____ Anticipated due date_____

Self Assessment

How would you rate your diet? (terrible) 1 2 3 4 5 6 7 8 9 10 (great)

How would you rate your stress level? (terrible) 1 2 3 4 5 6 7 8 9 10 (great)

How would you rate your physical health? (terrible) 1 2 3 4 5 6 7 8 9 10 (great)

How would you rate your health overall? (terrible) 1 2 3 4 5 6 7 8 9 10 (great)

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the service provider. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate services/care.

_____

Member's Signature

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AUTHORIZATION FOR CARE/CONSENT (Chiropractic care)

I hereby authorize the Doctor(s) to work with my condition through the use of spinal adjustments, as he or she deems appropriate. . I have stated all my known medical conditions and shall hold RESET Inc., staff and independent contractors free from liability of injury including death while on the premises. The Doctor(s) will not be held responsible for any medical diagnosis**. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable.**

Patient or Guardian Signature_____ Date:_____

AUTHORIZATION FOR CARE/CONSENT (Massage Therapy)

I hereby authorize the massage therapist (s) to work with my condition through the use of massage therapy, as he or she deems appropriate. I understand the massage services I receive are for relaxation, stress reduction and relief of muscular tension. I have stated all my known medical conditions and shall hold RESET Inc., staff and independent contractors free from liability of injury including death while on the premises. The Message Therapist(s) will not be held responsible for any medical diagnosis**. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable.**

Patient or Guardian Signature_____ Date:_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print)_____

Patient or Guardian Signature_____ Date_____

CA Signature_____ Date_____