REPLENISH
CHIROPRACTIC

FILE #: _____

PERSONAL INFORMATION	
Full Name	Today's Date
Street Address	Date of Birth Age
City | State | Zip	Sex
Email	Cell Phone
Occupation	Marital Status
Are you pregnant?	Are you active military?
Family member(s) names and ages	
How did you hear about Replenish Chiropractic?	

CURRENT HEALTH CONCERN(S)				
Health Concern (in order of severity)	Present Severity (1-10, 10 = worst)	How long have you had this?	Did this start with an injury?	Is this constant or does it come and go?
1.				
2.				
3.				
☐ *I do not have any current health conditions and seek wellness / maintenance / preventative care.*				

INFORMATION REGARDING YOUR ***PRIMARY*** HEALTH CONCERN
What makes the condition better? What makes this condition worse?
When is the condition usually at its worst? AM / PM / Mid-Day / Late PM
Are you seeing any other providers for this condition? Y / N If yes, who & when?
How does this condition affect your daily life? ☐ Carrying Groceries ☐ Lift/Play with children ☐ Static standing ☐ Yard work ☐ Sitting to standing ☐ Read or concentrate ☐ Walking ☐ Laundry ☐ Climbing stairs ☐ Shower/Dressing ☐ Sweep/vacuum ☐ Drive ☐ Computer use ☐ Extending sitting ☐ Dishes ☐ Sleep

Have you been to a chiropractor before? Y / N If yes, who & when?

DID/DO YOU HAVE ANY OF THE FOLLOWING?

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Stroke ___ Cancer ___ Heart Disease ___ Spinal Surgery ___ Seizures ___ Spinal Bone Fracture

OTHER HEALTH CONCERNS/CONDITIONS

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

HISTORY OF PHYSICAL, CHEMICAL, & EMOTIONAL STRESS

Have you had any significant falls, surgeries, or other injuries? Y / N
If yes, please describe:

How would you rate your level of physical activity on a weekly basis?

1 2 3 4 5 6 7 8 9 10
sedentary moderately active highly active

How would you rate your quality of sleep?

1 2 3 4 5 6 7 8 9 10
low moderate high

How would you rate your current level of emotional stress?

1 2 3 4 5 6 7 8 9 10
low moderate high

Have you been in any auto accidents? Y / N
If yes, please describe:

Do you drink alcohol? Y / N If yes, how much and how often?

Do you smoke tobacco products? Y / N If yes, how much and how often?

Please list any medications or supplements you are currently taking:

GOALS - WHAT ARE YOU HOPING TO ACHIEVE WHILE UNDER CARE?

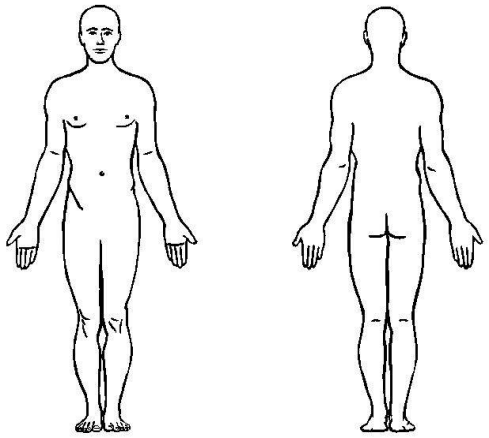
GOAL EXAMPLE: Get rid of my headaches. **SIGNIFICANCE:** I want to play with my kids without pain.

1.	
2.	
3.	

VISUAL DIAGRAM

Please mark the areas on the diagram with the following LETTER(S) to describe your symptoms:

R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/Stabbing **T**=Tingling



QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ *Back Pain* *Headaches* Worst possible pain

0 1 2 3 4 (5) 6 (7) 8 9 10

1. How would you rate your pain RIGHT NOW?_____

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain? _____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 is your pain at its best?)_____

_____0 1 2 3 4 5 6 7 8 9 10

- What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 is your pain at its worst?)

0 1 2 3 4 5 6 7 8 9 10

- What percentage of your awake hours is your pain at its worst? _____%

FOR OFFICE USE: Q1_____+ Q2_____+ Q4_____=_____/3x10=_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprains/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.
Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deem necessary and chiropractic care, including spinal adjustments, as reported following my assessment.

_____ _____

PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to 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. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's 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 to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE DATE

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular day of operation. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate medical pathology. The doctor of Replenish Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention, so you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____

PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE DATE

FEMALES ONLY: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken. _____
(initials)

WRITTEN CONSENT FOR A MINOR - if this health profile is for a minor, please fill out and sign below.

Name of patient who is a minor/child: _____

I authorize Dr. Brit'ny Richardson and any and all Replenish Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Replenish Chiropractic.

_____ _____
GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD DATE

TERMS OF ACCEPTANCE

To provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic.

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region, or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

_____ _____
PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE DATE

IN OFFICE PHOTOS

We love to have photos in our office! If you allow us to have your photo in the office, please sign below.
For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Replenish Chiropractic, or anyone authorized by Replenish Chiropractic, of any and all photographs/videos which are taken of myself and my child, for the purpose of promotional TV, website, social media, and print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Replenish Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, regarding any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Replenish Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected according to Health Information and Privacy Act Laws.

By my signature below, I authorize Replenish Chiropractic to take and use photos of me according to the terms above.

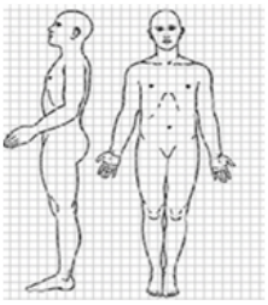
PATIENT'S SIGNATURE OR GUARDIAN SIGNATURE

DATE

OFFICE USE ONLY

Cervical ROM	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	90° ☐
Extension	☐	☐	☐	☐	☐	70° ☐
L Lat Flex	☐	☐	☐	☐	☐	45° ☐
R Lat Flex	☐	☐	☐	☐	☐	45° ☐
L ROT	☐	☐	☐	☐	☐	90° ☐
R ROT	☐	☐	☐	☐	☐	90° ☐

Lumber ROM	0%	25%	50%	75%	100%	Pain
Flexion	☐	☐	☐	☐	☐	90° ☐
Extension	☐	☐	☐	☐	☐	70° ☐
L Lat Flex	☐	☐	☐	☐	☐	45° ☐
R Lat Flex	☐	☐	☐	☐	☐	45° ☐
L ROT	☐	☐	☐	☐	☐	90° ☐
R ROT	☐	☐	☐	☐	☐	90° ☐



Posture		
Area	**Findings**	
F H P	+	-
Head Tilt	R	L
Head Rot.	R	L
↑ Shoulder	R	L
Thor. Tilt	R	L
Thor. Trans.	R	L
↑ Hip	R	L
Hip Rot.	R	L
Foot Flare	R	L