Confidential Patient Information

Welcome to Affinity Chiropractic

You are about to under go an extensive holistic health evaluation. Since we evaluate your structural, chemical, and mental health, the questions we ask are thorough and comprehensive. We will utilize the patient information forms you fill out, along with your history, lab work, and a chiropractic exam to properly evaluate your overall health. The doctor's findings from all the information will be presented at your report of findings during your second visit. Please take some time to complete this questionnaire. The questions in this questionnaire are comprehensive for overall health and wellness. We need this information in order to provide complete and total care.

We look forward to working with you and are privileged to help you achieve your health and wellness goals.

Name_____ Date____/____/_____

Personal Information

Date of Birth____/____/_____ Age_____ Social Security # _____-_____-_____

Address_____ Home Phone (____) _____

City_____ Cell Phone (____) _____

State_____ Zip_____ Email Address _____

Marital Status (circle one) S M W D Spouse's Name _____

Employment Information

Occupation_____ Occupation_____

Employer_____ Employer_____

Insurance Information (or bring a copy of your insurance card with you to your initial visit)

Do you have health insurance? ____Yes ____No Is your visit related to a work accident?___Yes ___No

Ins. Company_____ Have you reported it to your employer?___Yes ___No

Policy #_____ Is your visit related to an auto accident?___Yes ___No

Member #_____ If work/auto related: Date of Accident ___/___/_____

Health History

What is your major complaint?_____

How long have you had this condition? _____Years _____Months

Is this condition: _____Improved _____Unchanged _____Getting Worse

Please give brief history of this condition?_____

_____

Have you had this or similar conditions in the past? Please explain_____

Please lest any doctors or therapists who have treated this condition: (May I contact them for an update?) _Y _N

_____ _____

_____ _____

Have you ever been under Chiropractic Care? ___Yes ___No If yes, when?_____

What was the nature of your previous Chiropractic Treatment? _____

Pleases list your health goals that you would like to obtain by getting treated at Affinity Chiropractic.

1._____ 2._____

3._____ 4._____

Please rate the following by putting an X on the grid in the place that best describes you at this time:

Energy Level

[_____]

No Energy Most Energy Possible

If your energy is lower than desired, when is it typically decreased?

_____in the morning _____in the afternoon _____at night _____after meals

Current Health

[_____]

No Health As Healthy as Possible

What do you think is keeping you from being the healthiest you can be?_____

_____

What do you believe you need to do to increase your health?_____

_____

Stress Level

[_____]

No Stress Extremely Stressful

Please list the major stressors in your life:_____

Commitment to Health

[_____]

No Commitment As Committed as Possible

Please place a "C" next to any of the following symptoms/conditions that you are experiencing currently and a "P" next to any of the following symptoms/conditions you have experienced in the past.

General
___ Headache
___ Fever
___ Chills
___ Night sweats
___ Fainting
___ Anxiety
___ Depression
___ Loss of sleep
___ Fatigue
___ Nervousness
___ Weight loss
___ Allergies (list)
incontinence
_____
_____

Muscle/Joint/Nerve
___ Neck Pain
___ Back Pain
___ Arm/Leg Pain
___ Arm/Leg numbness
___ Weakness
___ Twitching
___ Tremors
___ Swollen joints
___ Scoliosis
___ Hernia
___ Dizziness
___ Convulsions

Gastro- intestinal
___ Appetite changes
___ Indigestion
___ Excessive hunger
___ Belching/Gas
___ Nausea
___ Vomiting
___ Vomiting blood
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Painful BM
___ Hemorrhoids

___ Liver disease
___ Jaundice

Cardiovascular
___ High Cholesterol
___ Heart attack
___ Chest pain
___ Stroke
___ Rapid heart rate
___ Slow heart rate
___ High blood pressure
___ Low blood pressure
___ Palpitations
___ Varicose Veins
___ Swollen ankles
___ Poor circulation

Eye/Ear/Nose/Throat
___ Poor vision
___ Blurred vision
___ Pain in eyes
___ Difficulty Hearing
___ Earache
___ Ear ringing
___ Ear discharges
___ Nasal congestion
___ Nose bleeds
___ Sore throat
___ Hoarseness
___ Hay fever

___ Itchy eyes
___ Frequent colds
___ Enlarged thyroid
___ Tonsillitis
___ Sinus pressure

Skin
___ Acne
___ Skin eruptions
___ Itching
___ Bruising easily
___ Dry skin
___ Hives
___ Eczema
___ Rash
___ Sensitive skin

Respiratory
___ Chronic cough
___ Spitting blood
___ Spitting phlegm
___ Wheezing
___ Shortness of breath
___ Asthma

Genito-urinary
___ Frequent urination
___ Painful urination
___ Blood in urine
___ Urinary

___ Difficulty Initiating

Women
___ Painful periods
___ Excessive flow
___ Irregular cycle
___ Hot flashes
___ No Period
___ Miscarriage
___ Vaginal discharge
Last pap ___/___/___

Men
___ Prostate trouble
___ Erectile dysfunction
___ Testicular pain

Exercise
☐None
☐Infrequent
☐Daily
☐Heavy

Work Activities
☐Sitting
☐Standing
☐Light Labor
☐Heavy labor

Social Habits
☐Smoking
☐Alcohol
☐Caffeine
☐High Stress

Packs/day_____
Drinks/week_____
Amount/day_____
Reason_____

	Yes	No	Don't Know
As a child:			
Were you a full term baby?	____	____	____
Were you breast fed?	____	____	____
Were you fully vaccinated?	____	____	____
Currently or in the past: (Use C for current and P for past)			
Have you been exposed to 2nd hand smoke regularly?	____	____	____
Have you had mercury amalgam fillings?	____	____	____
Have you received the annual flu shot?	____	____	____
Have you been sensitive to perfumes or fragrances?	____	____	____
Have you lived on a farm?	____	____	____
Have you had trouble sleeping?	____	____	____
Have symptoms immediately after eating?	____	____	____
Have symptoms 30-60 minutes after eating?	____	____	____
Do you crave certain foods?	____	____	____
If so, which ones?			
Do you have aversion to certain foods?	____	____	____
If so, which ones?			

Current Supplements	Taken For	Please List any injuries and Dates
_____	_____	_____ __/__/___
_____	_____	_____ __/__/___

Current Medications	Taken For	Please List and Surgeries and Dates
_____	_____	_____ __/__/___
_____	_____	_____ __/__/___

Previously have you taken any of the following medications: Antibiotics, birth control pills, or steriods? __Yes __No

Are you currently on any special diet (Diabetic, Vegan, South Beach, Atkins, ect)?

I understand that a Doctor of Chiropractic does not prescribe medications. Chiropractic is a Complimentary and Alternative Medicine Health Care Profession. I also understand that if want to change/get off my medications, I need to speak to my prescribing Doctor or a Pharmacist before doing so.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of Affinity Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. By signing below I certify that the information above is complete and accurate to the best of my knowledge.

_____ ____/____/_____

Signature (Patent or guardian if patient is under 18 years of age.) **Date**

Identi-T™ Stress Assessment

Name _____ **Age** _____ **Sex** _____ **Date**_____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1.	Get wound up when I get tired and have trouble calming down	0	1	2	3
2.	Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3.	Feel restless, agitated, anxious, and uneasy	0	1	2	3
4.	Feel easily overwhelmed by emotion	0	1	2	3
5.	Feel emotional — cry easily or laugh inappropriately	0	1	2	3
6.	Experience heart palpitations or a pounding in my chest	0	1	2	3
7.	Am short of breath	0	1	2	3
8.	Am constipated	0	1	2	3
9.	Feel warm, over-heated, and dry all over	0	1	2	3
10.	Get mouth sores or sore tongue	0	1	2	3
11.	Get hot flashes	0	1	2	3
12.	Sleep less than seven hours a night	0	1	2	3
13.	Have trouble falling asleep and staying asleep	0	1	2	3
14.	Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15.	Forget to eat and feel little hunger	0	1	2	3

Total points: _____

Section B:

1.	Find myself worrying about things big and small	0	1	2	3
2.	Feel like I can't stop worrying, even though I want to	0	1	2	3
3.	Feel impulsive, pent up, and ready to explode	0	1	2	3
4.	Get muscle spasms	0	1	2	3
5.	Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6.	See, hear, and smell things that others do not	0	1	2	3
7.	Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8.	Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9.	Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over	0	1	2	3
10.	Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3

Total points: _____

Section C:

1.	Have muscle and joint pains	0	1	2	3
2.	Have muscle weakness	0	1	2	3
3.	Crave salt or salty things	0	1	2	3
4.	Have multiple points on my body that when touched are tender or painful	0	1	2	3
5.	Have dark circles under my eyes	0	1	2	3
6.	Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7.	Use medications to manage pain	0	1	2	3
8.	Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9.	Have diarrhea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10.	Have headaches	0	1	2	3

Total points:

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
_____	_____	_____
_____	_____	_____

Financial Policy

I, _____ understand the following:

If you Do Not Have Insurance:
All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated.

If You Have Insurance:
Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses. All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim form for your secondary carrier.

Ours fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take and active part in the recovery for your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility of payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits if once per month or longer, you will not be eligible for insurance assignment charges for services rendered will be due as they are rendered.

General Provisions:
Your treatment schedule is subject to change at the doctors discretions. Any changes will be discussed prior to any alterations being made and cost adjusted accordingly. All costs explained to you are estimates and you are responsible for all charges incurred for services provided. The benefits verified with your insurance carrier are not a guarantee of payment. You are responsible for any unpaid balance associated with any treatment. If you discontinue care, for any reason other than discharge by the doctor, all balances will become immediately due and payable in full regardless of any claim submitted. If payments are not made as agreed upon, all balances will become immediately due and payable in full regardless of any claim submitted. In any of these cases Affinity Chiropractic is authorized to use the credit card on file to collect full payment.

I have read and understand the information provided above.

_____ ____/____/_____

Signature Date

CANCELLATION POLICY

Effective 4/12/2010

Our Cancellation policy is as follows: We are requiring that you give a 24-hour notice for all cancellations. If you cancel your appointment less than 24 hours prior to your appointment or you do not show, you will be charged the full amount of the appointment(s). Thank you in advance for your cooperation we appreciate your support.

Patient Name:_____

Patient signature:_____ **Date:** _____