Welcome to

Anchor Chiropractic

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask us. All of your questions, even the ones you haven't thought of yet, will be answered during your Chiropractic Report.

Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

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Personal and Family Health History

Name ____
Date _________________
Address ______________________________________
City ____________________ State ____ Zip ________
Phone: (H) _______________ (C/W)_______________
E-mail ____
Date of Birth _______________ (Age ______)

Referred By __________________________________
Social Security # ______________________________
Occupation ____________________________________
Employer _____________________________________
Marital Status S M D W
Spouse's Name ____________________DOB_______
Spouse's Occupation ___________________________

Number of Children and Ages ***Previous Chiropractic Care?***

Name ____________________________ Age _____ Yes___ No___ Reason ______________________________
Name ____________________________ Age _____ Yes___ No___ Reason ______________________________
Name ____________________________ Age _____ Yes___ No___ Reason ______________________________
Name ____________________________ Age _____ Yes___ No___ Reason ______________________________

You deserve to be healthy. When you were conceived, you were given the blueprints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply	*Patient*	*Spouse*	*Child#1*	*Child#2*	*Child #3*	*Chiropractor's Comments*
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	________
Difficult Delivery?	Y	Y	Y	Y	Y	________
Forceps?	Y	Y	Y	Y	Y	________
Caesarian?	Y	Y	Y	Y	Y	________
Breach/cephalic?	Y	Y	Y	Y	Y	________
Home birth?	Y	Y	Y	Y	Y	________
Mother given drugs during delivery	Y	Y	Y	Y	Y	________
Induced Labor?	Y	Y	Y	Y	Y	________
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	________
Fall out of bed?	Y	Y	Y	Y	Y	________
Bang your head?	Y	Y	Y	Y	Y	________
Breastfeed?	Y	Y	Y	Y	Y	________
Childhood sickness?	Y	Y	Y	Y	Y	________
Have any Accidents?	Y	Y	Y	Y	Y	________
Have Surgery?	Y	Y	Y	Y	Y	________
Take Drugs?	Y	Y	Y	Y	Y	________
Fall while learning to walk?	Y	Y	Y	Y	Y	________
Bullied by your siblings?	Y	Y	Y	Y	Y	________
Child abuse	Y	Y	Y	Y	Y	________
Pulled ear/chin	Y	Y	Y	Y	Y	________
Other	Y	Y	Y	Y	Y	________
Chair pulled out when sitting?	Y	Y	Y	Y	Y	________
Fall down the stairs?	Y	Y	Y	Y	Y	________
Pulled by your arm?	Y	Y	Y	Y	Y	________
Experience other traumas?	Y	Y	Y	Y	Y	________
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	________
Drink	Y	Y	Y	Y	Y	________
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	________
Have you been in accidents?	Y	Y	Y	Y	Y	________

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Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	________
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	________
Have Teeth Problems?	Y	Y	Y	Y	Y	________
Have Eye Problems?	Y	Y	Y	Y	Y	________
Have Hearing Problems?	Y	Y	Y	Y	Y	________
Exercise regularly?	Y	Y	Y	Y	Y	________
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	________
Have occupational stress?	Y	Y	Y	Y	Y	________
Have physical stress?	Y	Y	Y	Y	Y	________
Have mental stress?	Y	Y	Y	Y	Y	________
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	________
Sleeping posture (side–stomach–back)	______	______	______	______	______	________

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
Major ____
Pain or Problem started on____
Pains are: ❐ Sharp ❐ Dull ❐ Constant ❐ Intermittent
What activities aggravate your condition/pain? ______________________________
What activities lessen your condition/pain? ______________________________
Is condition worse during certain times of the day? ______________________________
Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? _______
Is this condition getting progressively worse? ______________________________
Other Doctors seen for this condition ______________________________
Any home remedies? ____

Other symptoms:

❐ Headaches	❐ Face Flushed	❐ Light Bothers Eyes	❐ Feet Cold
❐ Neck Pain	❐ Neck Stiff	❐ Loss of Memory	❐ Hands Cold
❐ Sleeping Problems	❐ Pins & Needles in Legs	❐ Ears Ring	❐ Stomach Upset
❐ Back Pain	❐ Pins & Needles in Arms	❐ Fever	❐ Constipation
❐ Nervousness	❐ Numbness in Fingers	❐ Fainting	❐ Loss of Balance
❐ Tension	❐ Numbness in Toes	❐ Cold Sweats	❐ Buzzing in Ear
❐ Irritability	❐ Shortness of Breath	❐ Loss of Smell	
❐ Chest Pains	❐ Fatigue	❐ Loss of Taste	
❐ Dizziness	❐ Depression	❐ Diarrhea	

Have you been under drug and medical care? ____
What medications are you taking? ____
How Long? ______________ Have you had surgery? ______________ What? ________ When?__________
What side effects have you experienced from the drugs and surgery? ______________________________

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______________
Father's Side	❐	❐	❐	❐	❐
Mother's Side	❐	❐	❐	❐	❐

Your oldest grandparent on record lived to the age of ________.

❐ Still living ❐ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❐ Feel better quickly ❐ Have a healthier spine and nervous system ❐ Live a healthier lifestyle

______________________________ Signature

______________ Date

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Office Fee Schedule and Financial Policy

Service	**Fee**
Meet the Doctor Visit	$ Complimentary
Initial History and Examination	$ 60 - 200 (most are $136)
X-Rays	$ 160 (full spine survey)
ReExams	$ 68
Adjustment	
spinal	$ 55 - 72 (most are $63)
extremity(s) [eg. wrist, ankle, knee]	$ 11 extra

Financial Policy and 100 Year Lifestyle Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care (fees listed above) at the time services are rendered unless you arrange a 100 Year Lifestyle Plan in advance.** 100 Year Lifestyle Plans include Crisis Care, Critical Transition Care, and Lifestyle Care. They are designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

If you have health insurance that covers chiropractic (and choose to use it), you will be charged the fees listed above. While we will file your insurance claim on your behalf, please remember in the event of a dispute, your agreement with your insurance company is between you and them. You are expected to pay any copays and/or percentages with necessary deductibles at the time of service. If the exact amount is unknown, based upon our experience, we will arrive at an estimated amount. Any unpaid balances remaining after your insurance claim has been processed will be billed to you, and payment will be due upon receipt. In situations in which you have overpaid, depending on your preference, a credit or refund will be issued to you. Please note that insurance companies only cover Crisis Care and do NOT cover Critical Transition or Lifestyle Care.

(Discounts may be extended to Individuals/Families if the requirements for our financial assistance program are met. If you are interested, please ask for a hardship application).

I, ___________________________________ have read and I understand the above

name

____

signature date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read and fully understand the above statements.

name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_______________________________________ ________________________

signature date

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ANCHOR CHIROPRACTIC

PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree to the following:

1. I understand that this Patient Consent is a summary of the Anchor Chiropractic's 5-page Privacy Notice which is available for my review by inquiring at the front desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Anchor Chiropractic (hereinafter referred to as "the Practice") to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand, and consent to, appointment reminders which may be utilized by the Practice. Appointment reminders may include, but are not limited to: automated texting and/or voice calls, standard telephone calls, postcards, voice mail messages or messages with the individual answering the telephone.

4. I understand, and consent to, the Practice having the option of recognizing me by listing my name in the Practice newsletter (electronic or print) should I refer a patient to the office.

5. I understand, and consent to, that if I have been referred to the Practice by another patient, that patient may receive a "Thank you," whether verbally or by letter (electronic or print) which will reference my name.

6. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

7. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

9. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

10. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice has the right to refuse to treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship
Date Signed ______/______/______	Witness:______________________