



WELCOME!



Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ M W D S  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Emergency Contact/ Relation/ Phone: \_\_\_\_\_  
 \_\_\_\_\_  
 #of Children & Ages: \_\_\_\_\_  
 Favorite Hobbies or Interests: \_\_\_\_\_  
 \_\_\_\_\_

**History**  
**Current Health Complaints/ Reasons for Consulting Our Clinic**

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_

Injury Occurred:  Automobile  Work  Other: \_\_\_\_\_  
 Injury Date: \_\_\_\_\_  
 Injury Origin: \_\_\_\_\_  
 Discomfort Frequency:  Always  Hourly  Daily  Occasionally  
 Missed Work: Yes No  
 Does it worsen: Yes No  
 Aggravates Condition: \_\_\_\_\_  
 Improves Condition: \_\_\_\_\_  
 Have you had the same or similar problem(s) before? If so, for how long?  
 \_\_\_\_\_

Other doctors you have seen for this problem: \_\_\_\_\_  
 Interfere w/ Activities: Yes No Affected Sleep: Yes No  
 Previous Chiro care: Yes No Date: \_\_\_\_\_ Explain: \_\_\_\_\_  
 Surgeries you have had: \_\_\_\_\_  
 Medication you currently take: \_\_\_\_\_  
 Is Chance Pregnant: Yes No Planning: Yes No  
 Have you ever been diagnosed with cancer? \_\_\_\_\_ If so what kind? \_\_\_\_\_

Broken Bones: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Sprains/Strains: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Hospitalized: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Surgery: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Eating Disorder: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Stroke: Yes No Treatment: Yes No Explain: \_\_\_\_\_  
 Family Health Hist: \_\_\_\_\_

**Patient Social**

Alcohol:	Daily	Weekly	Occasion	Never
Homemade Food:	Daily	Weekly	Occasion	Never
Exercise:	Daily	Weekly	Occasion	Never
Processed Food:	Daily	Weekly	Occasion	Never
Tobacco:	Daily	Weekly	Occasion	Never

**Interest of Additional Services**

Chiropractic Care Plans:	Yes	No
Massage Therapy:	Yes	No
Acupuncture:	Yes	No
Workshops:	Yes	No

**How did you hear from us?**

- Internet Search
- Friend/Family/Co-worker (Name): \_\_\_\_\_
- Zen Healing Center Coupon
- Outside ADD

**Appointment Reminders**

It is okay to leave message:  Home phone  Work phone  Mobile Phone

If unable to reach me:

You may leave a detailed message

Leave a message asking me to return your call

Do not leave a message

Is it okay to send you a text message or e-mail about your appointment: Yes No

If yes, please provide the following information:

Text Message: \_\_\_\_\_ (Mobile phone number)

Select your cell phone carrier:  AT&T  Sprint  T-Mobile  Verizon Other: \_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

## THE STRESS TEST

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses? Please circle when you experienced these stresses: C (Child), T (Teenager), A (Adult), or N (Not at all).

**1. PHYSICAL STRESS:**

**EXPLAIN**

Birth Traumas (as a moth or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Care Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet for years	C	T	A	N	_____
Sleeping Position – Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Book bag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Hours Sitting/Standing	C	T	A	N	_____
Bone Fracture/Surgery	C	T	A	N	_____

**2. EMOTIONAL STRESS:**

**EXPLAIN**

Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Finance	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

**3. CHEMICAL STRESS:**

**EXPLAIN**

Environment (i.e. Pollution)	C	T	A	N	_____
Second- hand smoke	C	T	A	N	_____
Caffeine – Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners (sugar substitute)	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs (Example: Tylenol; Motrin)	C	T	A	N	_____

**4. What do you feel is your primary stress?**

\_\_\_\_\_

\_\_\_\_\_



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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): \_\_\_\_\_

Family Medical History (Record one diagnosis in your family history and the affected relative)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For office use only</b>		
Height: _____	Weight: _____	Blood Pressure: _____ / _____



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### **TERM 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 toward the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and method that will be used 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 adjustment of the spine. **Health:** A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

**Vertebral Suluxation:** 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 examination, we encounter non-chiropractic or unusual finding, 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 diseases are 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, \_\_\_\_\_(Print name) have read and fully understand the above statements.

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.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the use and disclosure of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*These forms are provided as a service to subscribers to [www.hhs.gov](http://www.hhs.gov) and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.*



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### FINANCIAL POLICY

Thank you for choosing Zen Chiropractic Inc. for your care. We ask that all patients read and sign our Financial Policy as well as complete our patient information forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, are due at the time services are rendered. We accept cash, personal checks, and credit cards for payment. We do our best to inform you of an estimated cost of services prior to your visit. We are in-network with some insurance companies such as Blue Cross, Humana, Medicare, Medicaid, Workers Compensation, and Auto Insurance). Please understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We cannot guarantee any payments coming from your health insurance.
2. All charges are your responsibility whether your insurance company pays or not. Our company will accept financial responsibility for claims not filed correctly or in a timely manner. You are responsible for providing our company with correct and current demographic and insurance information in order for us to bill your insurance.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance within 45 days we ask that you contact the carrier to request prompt payment. Please inform our company of the carrier's response.
5. Returned checks will be subject to a \$30.00 collection charge. If the check is not picked up and payment made within 10 days, we will turn the check over to law enforcement.
6. Unpaid balances over 90 days will be sent to collections via small claims court, attorney, and/or collection agency with applicable collection fees.

#### **Authorization to Release and Assign Insurance Benefits**

I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Zen Chiropractic Inc. benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims, until I choose to revoke it in writing. At such point I will become responsible for filing my insurance claims.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my treatment at Zen Chiropractic Inc.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_