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 * Welcome…Namaste*

***Chiropractic for a World of Difference***

*Your first visit to our office is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life as well as what you would like to move toward. You may also find ideas about who you are and your true health and life potentials expanding as you take your first step with us on your joyous journey toward ever-higher levels of health, wellness and wholeness.*

***And away we go!***

**Confidential Personal Information:**

|  |
| --- |
| **Full name: Date:** |
| **Address (street, apt #, city, state, zip):**  |
| **Home phone:**  | **Work phone:** |
| **Cell phone:** | **Email address:** |
| **Best time/place to contact you:** |
| **Date of birth:** | **Age:** |
| **Occupation and Employer:** |
|  |
| **Marital status: M S W D Other:\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Partner’s name:** |
| **Partner’s Occupation:** |
| **No. of children: How many at home?** **(Names / birth year):** | **Pregnant ☐ Yes ☐ No ☐ N/A**  |
| **Name of person responsible for account:** |
| **Who May we thank for referring you?**  |

Have you been to a chiropractor before? [ ]  YES [ ]  NO Last visit date?

Was it for: [ ]  Specific concern [ ]  Wellness

If known, name of previous chiropractor:

**Addressing what Brought you to this Office:**

*If no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to* ***“General Health History”****.*

**Health Concerns**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please list your health concerns according to their severity | Rate of severity1 = mild10 = worst imaginable | When did this episode start? | If you had this condition before, when? | Did the problem begin with an injury? | % of the time pain is present |
| 1.  |   |  |  |  |  |
| 2.  |  |  |  |  |  |
| 3.  |  |  |  |  |  |
| 4.  |  |  |  |  |  |

**Is your pain dull or is it sharp? Does it radiate anywhere, and if so, where?**

|  |
| --- |
|  |

**Since the problem has started, is it:** **[ ]** About the same [ ]  Getting better [ ]  Getting worse

**Is this condition interfering with any of the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Work | **[ ]** Sleep | **[ ]** Daily routine | **[ ]** Sports/exercise | **[ ]** Other (explain):  |

**What lesson(s) have you taken home from your healing process to date?**

|  |
| --- |
|  |
|  |

**What have you done for this condition? Was it of benefit?**

|  |
| --- |
|  |

**Is there family history of the same/similar condition?**

**[ ]** Yes (please explain below) [ ]  No

|  |
| --- |
|  |

**What activities aggravate your condition?**

|  |
| --- |
|  |

The unique service we provide at Rhodes Family Chiropractic is to simply help your body to work better. When your body works normally, it can heal just about anything. It’s not about having less of some undesirable symptom or disease, but more of a good thing -- a body that’s more in tune with what makes it heal and grow in the first place. Not less disease, more life.

“It’s better to light one candle than to curse the darkness.” B.J. Palmer

**What we do here is not a form of medicine or alternative medicine**. Medicine specializes in diagnosing and treating what’s wrong. Chiropractic is very different. We promote normal function of your amazing body by focusing on what’s *right* with you. We recognize that healing can be blocked by accumulated stress and what we do here is unblock it. We perform specific, scientific chiropractic adjustments to reduce subluxation, the disconnect between brain and body. We are not going to diagnose or treat “your condition/symptom”. Chiropractic works to express the power that runs your living body, not suppress its symptoms. We are going to help your body (etc.) resume normal function so you can get better and better. If you want medical treatment or advice, that’s fine. That’s what medical folks do. You know where to find them. You can do both if you want. Here, we work with the power that made and heals your body. We get results with no side effects. THIS STUFF WORKS!

Our objective is to address vertebral subluxation and help you to keep from recreating nerve interference and damage.

***Chiropractic is a highly specialized field requiring specific training. Should you be provided with an expert opinion on chiropractic by any Health Care Professional who is not trained in chiropractic, please contact us immediately.***

Return Policy:

We’ll recommend when to return for best results. Should you choose to stop having care at any time, that’s your choice. Please let us know so we can celebrate the steps you have taken. You’ll be welcomed back at any time. Regular chiropractic care is an essential component to living long and well.

“If you never plant flowers, you’ll be forever pulling weeds.”

I,     , understand. I get it: [ ]  Kind of [ ]  Totally

I consent to a professional and complete chiropractic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

|  |  |
| --- | --- |
| Print Name:  | Date: |

**Signature:**

---------------------------------------------------------------------------------------------------------------------------------------------------

**Emergency Contact:**

|  |  |  |
| --- | --- | --- |
| Name:  | Phone #:  | Relationship: |

**Let’s Take a Deeper Look**

**MAJOR OR PERSISTENT STRESSORS (GOOD AND BAD STRESSES COUNT):**

Because accumulation of stress affects our health and ability to heal **please list your top three stresses** (you have ever had) in each category:

1. Physical stress (falls, accidents, broken bones, etc…)
2.

b)

1.
2. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

b)

1. Bio-chemical stress (smoke, unhealthy foods, missed meals, drugs/alcohol, etc…
2.

On a scale of 1-10 (1 being very low and 10 being high) please grade your present levels of **stress** (including physical, bio-chemical and psychological or mental/emotional):

|  |  |  |
| --- | --- | --- |
| At work:  | At home: | At play:  |

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Eating habits:  | Exercise habits: | Sleep: | General health: | Mind set: |

How do you grade your physical health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

How do you grade your emotional/mental health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

**General Health History**

***Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!***

Have you had any surgery? (Please include all surgery)

|  |  |  |
| --- | --- | --- |
| 1. Type:  | When? | Doctor |
| 2. Type: | When?  | Doctor |
| 3. Type: | When? | Doctor |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially related to present problems).

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Hospitalized? Yes □ No □ |
| 2. Type: | When?  | Hospitalized? Yes □ No □ |
| 3. Type: | When? | Hospitalized? Yes □ No □ |

Have you ever had x-rays taken?

|  |  |  |
| --- | --- | --- |
| Area of body:  | When? | Where? |

Do you wear orthotics or heel lifts? [ ]  Yes [ ]  No

What are you currently doing to increase your health?

|  |
| --- |
|  |

**Current Medicines/Supplements/Healthy Lifestyle Habits**

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

|  |
| --- |
|  |

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

|  |
| --- |
|  |

The type of diet I usually follow is classified as:

|  |
| --- |
|  |

What healthy lifestyle habits are you currently practicing?

|  |
| --- |
|  |

**Past Health History** Please mark the following conditions. **Leave blank if never experienced**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcoholism□ Have had□ Current | Allergy □ Have had□ Current | Anemia□ Have had□ Current | Arteriosclerosis□ Have had□ Current | Arthritis □ Have had□ Current | Asthma □ Have had□ Current |
| Back Pain□ Have had□ Current | Cancer□ Have had□ Current | Cold Sores□ Have had□ Current | Constipation □ Have had□ Current | Convulsions□ Have had□ Current | Depression□ Have had□ Current |
| Diabetes□ Have had□ Current | Diarrhea□ Have had□ Current | Eczema□ Have had□ Current | Emphysema □ Have had□ Current | Epilepsy □ Have had□ Current | Gall Bladder Problems□ Have had□ Current  |
|  Gout□ Have had□ Current | Headaches □ Have had□ Current | Heart Attack□ Have had□ Current  | Heart Disease □ Have had□ Current | High Blood Pressure□ Have had□ Current | HIV (Aids)□ Have had□ Current |
| Irregular Periods□ Have had□ Current | Low Blood Sugar□ Have had□ Current | Malaria□ Have had□ Current | Measles□ Have had□ Current | Menstrual Cramps□ Have had□ Current | Migraine □ Have had□ Current |
| Miscarriage□ Have had□ Current | Multiple Sclerosis□ Have had□ Current | Mumps□ Have had□ Current | Neck Pain□ Have had□ Current | Nervousness □ Have had□ Current | Neuritis□ Have had□ Current |
| Pleurisy □ Have had□ Current | Pneumonia □ Have had□ Current | Polio □ Have had□ Current | Rheumatic Fever□ Have had□ Current | Ringing in ears□ Have had□ Current | Sinus Problems □ Have had□ Current |
| Stroke□ Have had□ Current | Thyroid Problems□ Have had□ Current | Tuberculosis □ Have had□ Current | Ulcers □ Have had□ Current | Venereal Disease□ Have had□ Current | Whooping Cough□ Have had□ Current |



Other:

**Anything else???**

|  |
| --- |
|  |

Humans can endure a lot. What tipped the scale to bring you in today?

|  |
| --- |
|  |

*Thank you for sharing this information with us.*

**HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**Signature:**

 **Date:**