CHIROPRACTIC
INTEGRATION

For Office Use Only

Date _____

Pt. ID_____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Both Parent's names (if under 18)_____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Business Phone (____)_____

Cell Phone (____) _____SSN#_____

E-mail address_____ _____

Occupation _____ Employer_____

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner

_____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

What concerns do you feel Chiropractic Integration can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:

_____

_____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

If you have recently delivered a child, how long ago? _____ Where? _____

Health, Wellness and Chiropractic Care

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

****Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.**

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.
Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

How many bowel movements do you have in a day? _____

How much water do you consume per day? _____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall sleep quality? # of hours/night_____❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

❒ OTHER_____

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FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam, Consultation, and Report of Findings: $225.00

PLEASE READ AND SIGN

1. I acknowledge that some of the services offered by Chiropractic Integration may not be covered by insurance and I am responsible for all fees incurred during office visits.
2. I have been informed that a copy of Chiropractic Integration's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office.
3. I consent to receive communication from Chiropractic Integration via email, postal mail, text and telephone messaging in connection with my care.
4. I agree to follow doctor's recommendations to the abosulet best of my ability to ensure that I get tha absolute best results.
5. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctors at Chiropractic Integration permission to examine and render care. This initial visit includes a health history consultation, chiropractic exam and evaluation, neurological exam via infrared thermogprahy, x-rays and any initial care that is determined to be clinically necessary and mutually agreed upon.

Patient Name (Printed) _____

Signature _____ Date: _____

Signature of Parent or Legal Guardian if Minor_____ Date: _____

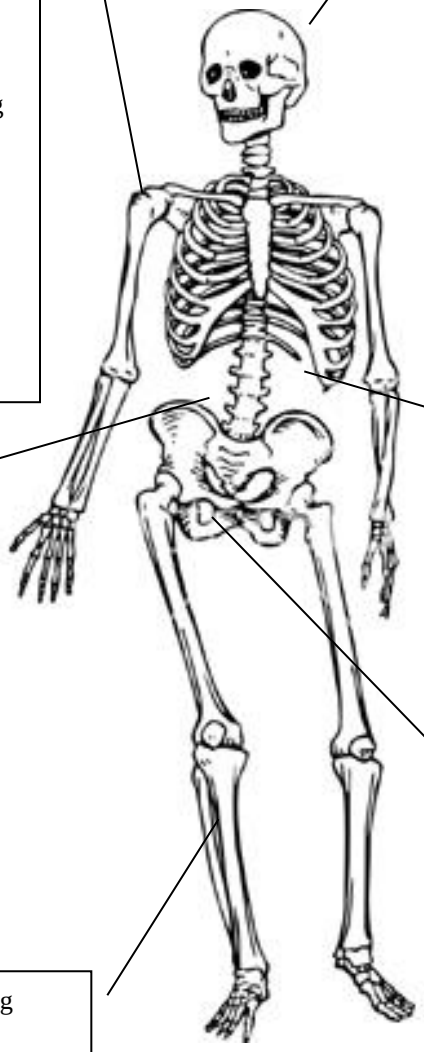
Thank you for choosing Chiropractic Integration.
We look forward to working with you and your family.

Personal Health History

Please check any box that applies to your health history previously or currently.

- ☐ Anxiety
- ☐ Fainting
- ☐ Lower Neck Pain
- ☐ Shoulder Pain
- ☐ Asthma/ Difficulty Breathing
- ☐ Seasonal Allergies
- ☐ Frequent Colds
- ☐ Pneumonia
- ☐ Torticollis
- ☐ Thyroid Dysfunction
- ☐ Fever/ Chills/ Cold Sweats
- ☐ Easily Bruised
- ☐ Abnormal Hair Growth

- ☐ Pain at Base of the Skull
- ☐ Migraines/Headaches
- ☐ Memory Loss
- ☐ Sensitivity to Light
- ☐ Vertigo/Dizziness
- ☐ Tinnitus/ Ringing In Ears
- ☐ Glasses/Double VIsion
- ☐ Numbness/Tingling
- ☐ Facial Pain
- ☐ Swollen Glands
- ☐ Tooth Decay/ Bleeding Gums
- ☐ Cold Sores and Acne
- ☐ Frequent Sneezing or Discharge
- ☐ Loss of Sleep



- ☐ Fatigue
- ☐ Skin Rash/ Eczema
- ☐ Pain Between Shoulders
- ☐ Food Sensitivities/ Allergies
- ☐ Indegestion
- ☐ Gas/ Bloating
- ☐ Diahrrhea / IBS / Constipation
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Kidney/ Gall Stones
- ☐ Lyme
- ☐ Unexplained Weight gain/loss
- ☐ Carpal Tunnell
- ☐ Tennis/ Golfers Elbow

- ☐ High Blood Pressure
- ☐ Heart Arrythmia
- ☐ Chest Pain
- ☐ Heart Burn/ Reflux/ GERD
- ☐ Ulcers
- ☐ Vomitting
- ☐ Anemia
- ☐ Lower Back/ Hip Pain

- ☐ Knee Pain/ Popping/ Grinding
- ☐ Varicose Veins
- ☐ Fluid in Legs/Edema
- ☐ Sciatic Pain
- ☐ Frequent Ankle Sprain
- ☐ Heel Lift/ Foot Orthotics
- ☐ Decreased Coordination/ Balance

Female:
- ☐ Abnormal Menses/ PMS
- ☐ Age of First Mense _____
- ☐ Number of Pregnancys ____
- ☐ Birth Control
- ☐ Frequent UTI
- ☐ Yeast Infection
- ☐ Decreased Sex Drive

Male:
- ☐ Erectile Dysfunction
- ☐ Frequent UTI
- ☐ Testicular Pain/ Swelling
- ☐ Hemmorhoids
- ☐ Prostate Issues

Drug Allergies: _____
Smoking history: _____
Medications: _____

Height_____Weight_____B/P_____RR_____Pulse_____Temp._____O2_____

HIPPA and Privacy Practice Notice

Patient Copy

The Privacy Practice Notice is available upon request beginning on the revision's effective date. The revised notice is made available to all patients, including those who have received a previous notice. Upon receipt of a revised notice, the patient is asked to acknowledge the receipt of the notice.

Complaints

The practice allows all patients and their agents to file complaints with the practice and with the Secretary of the Federal Department of Health and Human Services (DHHS). A patient or his or her agent may file a complaint with the practice whenever he or she believes that the practice has violated their rights. Complaints to the practice must be in writing, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. Complaints must be addressed to the attention of the practice's privacy officer at the practice address. The practice investigates each complaint and may, at its discretion, reply to the patient or patient's agent.

The practice does not take any adverse action against any patient who files a complaint (either directly or through an agent) against the practice.

Contact Person

The practice has a privacy officer that serves as the contact person for all issues related to the Privacy Rule. If you have any questions about this Notice, please contact our privacy officer at 586-843-0009 or by mail at Chiropractic Integration, Attn: Privacy Officer 4741 24 Mile Rd. Suite B. Shelby MI, 48316.

Uses and Disclosures of Protected Health Information

The practice reasonably ensures that the protected health information (PHI) it requests, uses, and discloses for any purpose is the minimum amount of PHI necessary for that purpose. The practice treats all qualified individuals as personal representatives of the patient. The practice generally allows individuals to act as personal representatives of patients. The two general exceptions to allowing individuals to act as personal representatives relate to the un-emancipated minors and abuse, neglect or endangerment situations. The practice makes reasonable efforts to unsure that protected health information is only used by and disclosed to individuals that have a right to the protected health information. Towards that end, the practice makes reasonable efforts to verify the identity of those using or receiving protected health information.

Uses and Disclosures- Treatment, Payment and Health Care Operations

The practice uses and discloses protected health information for payment, treatment and health care operations. Treatment includes those activities related to providing services to the patient, including releasing information to other health care providers involved in the patient's care. Payment relates to all activities associated with getting reimbursed for services provided.

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“2-4-6 Rules”

2 - Hours before your appointment please refrain from tobacco use and chocolate.

4 - Hours before your appointment please refrain from consuming any caffeinated beverages including coffee, energy drinks, soda, tea, or supplements containing this substance.

6 - Hours before your appointment please refrain from taking any medications or recreational drugs.

The “2-4-6” rules are necessary to ensure that your doctor is able to obtain an accurate neurologic scan. It is imperative to not only avoid the intake of such substances prior to your appointment, as well as after and in between each visit to ensure prolonged results.

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Terms of Acceptance

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

As a Doctor of Chiropractic, I have only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is 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 COMPLEX (VSC): A misalignment of one or more of the 24 vertebra of the spinal column which causes abnormal nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's 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 a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend 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 body's innate wisdom, the Vertebral Subluxation Complex (VSC).
(Initial) ____ I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I understand Dr. Iftikhar or the staff DO NOT guarantee results in any way.

I therefore accept chiropractic care on that basis.

Signature_____ Date: _____