Chiropractic Health
Dr. Art Vanderhoef

Print Form

Patient Information Form File #_____

Name_____ Date_____
Address_____ City_____ State_____ Zip_____
Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____
Email Address_____
How do you prefer to be contacted? □ Mail □ Home Phone □ Cell Phone (Carrier_____) □ Email
What time do you prefer? □ AM □ PM

Who do we thank for referring you to us? _____

Gender: □ Male □ Female Date of Birth____/____/_____ Age_____
Social Security #_____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered Spouse's Name_____
Spouse's Occupation_____ # of Children ____ Names & ages_____
Have you ever received Chiropractic Care? □ Yes □ No If yes, when, where, & why? _____
Emergency Contact Name _____ Emergency Contact Number ( ) _____

Employment Status: □ Employed □ Unemployed □ Full-time Student □ Part-time Student □ Retired
Employer Name_____ Occupation_____
Start Date_____ End Date_____

Insurance Information (We will make a photocopy of the card also)

Name of Insured_____ Relationship to patient_____
Insured's Social Security #_____-_____-_____ Date of Birth_____
Insurance Company_____ Insurance Phone ( ) _____
ID #_____ Group #_____

Certification and Assignment

- To the best of my knowledge, the above information is complete and correct. I understand this is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
- I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chiropractic Health Advantage all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
- I understand that I will be charged $25.00 for a missed appointment if I do not notify the office via phone or email at least 8 hours or earlier to the committed time schedule.

The above named doctor or office may use my health care information and may disclose such information to the above name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ _____
Signature of Patient Date

_____ _____
Please print name of Patient Date

Chiropractic Health

Dr. Art Vanderhoef

Patient Name: _____

Personal Health History

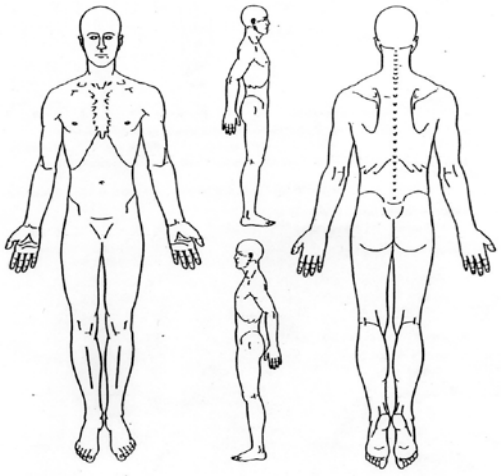
Date:_____ **File #:** _____

Reason for today's visit: ☐ **New Injury** ☐ **Chronic Pain** ☐ **Old Injury** ☐ **Reoccurrence**
Did your injury occur during: ☐ **Work** ☐ **Sleep** ☐ **Sports/Play** ☐ **Auto Accident** ☐ **Routine/Household Activity**

CHIEF SUBJECTIVE COMPLAINT: (briefly describe) _____
_____
When did your condition/accident occur? ____/____/____ **Where did your injury occur?**_____
Is your condition getting worse? ☐ **Yes** ☐ **No** ☐ **Comes and Goes**
Is your condition interfering with your: ☐ **Work** ☐ **Sleep** ☐ **Daily Routine** ☐ **Recreation**
If so, how?: _____
Has this or something similar happened in the past? ☐ **Yes** ☐ **No**
What have you been told is wrong? _____

Using the body chart below, please circle all affected areas:

Circle the symbols to best describe the type(s) of pain:
D = Dull Ache N = Numbness B = Burning
S = Sharp T = Tingling (pins & needles)



Are you in pain? ☐Yes ☐ No
Circle your pain on the following scale for each area of your body:

	(no pain)										(unbearable)
Neck	0	1	2	3	4	5	6	7	8	9	10
Middle Back Pain	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain	0	1	2	3	4	5	6	7	8	9	10
Other: _____	0	1	2	3	4	5	6	7	8	9	10

Have you been treated by a medical physician for this pain?
☐ **Yes** ☐ **No**
If Yes, where & when: _____

Have you ever been treated by a chiropractor?
☐ **Yes** ☐ **No**
If yes, where & when: _____

Are you taking any of the following medications?
☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin
☐ Anti-Inflammatory ☐ Steroids ☐ Other_____

Frequency of Pain:
☐ Constantly (76%-100% of the day)
☐ Frequently (51%-75% of the day)
☐ Occasionally (26%-50% of the day)
☐ Intermittently (0%-25% of the day)

Pain Better:
☐ AM ☐ At Rest
☐ Mid-Day ☐ Does Not Change
☐ PM ☐ Other

Pain Worse:
☐ AM ☐ At Rest
☐ Mid-Day ☐ Does Not Change
☐ PM ☐ Other

Do you or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/Drug abuse	Y N Venereal Disease	Y N Hepatitis	Y N Anemia/Diabetes
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problem
Y N High Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Artificial Bones/Joints	Y N Tuberculosis
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma	Y N Arthritis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower back Problems	Y N Severe/Frequent Headaches	

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Personal Health History

File #_____

Do you take any supplements or vitamins? ☐ **Yes** ☐ **No**
Do you exercise? ☐ **Yes** ☐ **No** **How many hours per week?** _____
Do you smoke? ☐ **Yes** ☐ **No** **How much?** _____ **How Long?** _____
Are you wearing? ☐ **Shoe lifts** ☐ **inner soles** ☐ **arch supports**
Are you dieting? ☐ **Yes** ☐ **No** **If yes, since when?** _____

For Women:

Are you taking birth control pills?	☐ **Yes**	☐ **No**	
Are you nursing?	☐ **Yes**	☐ **No**	
Are you Pregnant?	☐ **Yes**	☐ **No**	**If so, how many weeks:** _____
Do you have breast implants?	☐ **Yes**	☐ **No**	

- **To the best of my knowledge, the above information is complete and correct. I understand this is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.**

_____ _____
Signature of Patient, Parent, Guardian **Date**

_____ _____
Signature of Doctor **Date**

File #_____

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment Process: A series of specific force applications to facilitate the body's connection between itself and the intelligence that continually maintains it in existence. Our chiropractic method of connection is by specific adjustments of the spine.

Health: Also known as ease, this is the body's ability to overcome everyday stresses and continually grow through adaptation.

Vertebral Subluxation Process: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

Open Adjusting: We use open bay areas for routine adjustment and therapy visits. If you require a private area, one will be provided upon request.

We do not offer to diagnose or treat any disease. Our focus in this office is the body's fullest expression of LIFE and the roles that the vertebral subluxation process will/can have upon it. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate and analyze the vertebral subluxation process and the administration of the specific adjustment process to allow the free flow of innate intelligence throughout your body.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature_____Date_____

CONSENT TO EVALUATE AND ADJUST A MINOR

I,_____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature_____Date_____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period:_____

Signature_____Date_____

File #_____

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "your chiropractor" refers to Dr. Art Vanderhoef or Chiropractic Health Advantage.

I consent to the use or disclosure of my protected health information by your chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the chiropractor. I understand that analysis, diagnosis or treatment of me by your chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Your chiropractor is not required to agree to the restrictions that I may request. However, if your chiropractor agrees to a restriction that I request, the restriction is binding on your chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that your chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of your chiropractor and understand that I have a right that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of your chiropractor. The Notice of Privacy Practices from your chiropractor is also posted in the waiting room at Chiropractic Health Advantage. This Notice of Privacy Practices also describes my rights and duties of your chiropractor with respect to my protected health information.

Your chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of your chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____

Date of Signing

Submit by Email