JUBILEE FAMILY CHIROPRACTIC HEALTH PROFILE

Name________________________________Date____/___/________Age_____Male/Female

Address________________________________City______________State_____Zip_________

Phone Numbers: Home__________________________Cell__________________________

Email Address________________________________Date of Birth _____/_____/______

Occupation______________________________Employer's Name______________________

Single / Married / Divorced / Widowed Spouse's Name____________________________

Number of Children______ Names, Ages, & Gender___________________________________

____

Whom may we thank for referring you?____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1=mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Are symptoms constant or intermittent?
1.				
2.				
3.				
4.				
5.				

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE_______________

____

____

IF YOU ARE EXPERIENCING PAIN, IS IT _______SHARP _______DULL

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? _____YES _____NO IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE____

____

SINCE YOUR PROBLEM BEGAN, IS IT ____ABOUT THE SAME ____GETTING BETTER ____GETTING WORSE

WHAT MAKES IT WORSE? ____

WHAT HAVE YOU DONE THAT HELPS IT FEEL BETTER? ______________________________

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?___CHIROPRACTOR___MEDICAL DOCTOR ____OTHER WHO AND WHEN____

LIST SURGICAL OPERATIONS AND YEARS______________________________________

____

LIST ALL MEDICATIONS YOU ARE TAKING______________________________________

____

WHEN WAS YOUR LAST AUTO ACCIDENT______________________________________

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE____YES ____NO IF YES, DR. & DATE______________

HAVE YOU EVER BEEN: KNOCKED UNCONSCIOUS? ___YES ___NO FRACTURED A BONE? ___YES ___NO

IF YES, PLEASE DESCRIBE____

ANY OTHER BODILY TRAUMA?____

PLEASE CIRCLE ANY AND ALL PROBLEMS YOU HAVE HAD IN THE PAST 2 YEARS

ASTHMA	ARTHRITIS	TMJ	CHRONIC FATIGUE
EPILEPSY	GASTRIC REFLUX	HEART DISORDERS	LUPUS
ULCERS	SCIATICA	IRRITABLE BOWEL	NAUSEA
DIZZINESS	NUMBNESS IN ARMS	DISC PROBLEMS	MENSTRUAL DISORDER
KIDNEY PROBLEMS	NUMBNESS IN LEGS	LIVER DISEASE	NECK PAIN
HEADACHES	NUMBNESS IN HANDS	LOW BACK PAIN	MIGRAINES
VERTIGO	NUMBNESS IN FEET	MID BACK PAIN	STIFFNESS IN NECK
CHEST PAINS	EAR INFECTIONS	STOMACH DISORDER	HIP PAIN
ARM PAINS	GRATING IN NECK	LEG PAINS	ANXIETY
NERVOUSNESS	SHOULDER PAIN	FAINTING	CHRONIC SINUS

FAMILY HEALTH HISTORY

THE REASON FOR THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING
PAST HEALTH HISTORY INFORMATION
FOR THEIR REVIEW.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER	GRANDCHILDREN
ARM PAIN						
ARTHRITIS						
ASTHMA						
ADD / ADHD						
ALLERGIES						
BACK TROUBLE						
BED WETTING						
CARPAL TUNNEL						
CONSTIPATION						
DECEASED						
DEGENERATIVE SPINE						
DIGESTIVE PROBLEMS						
DISC PROBLEMS						
EAR INFECTIONS						
EAR / NOSE / THROAT						
FIBROMYALGIA						
HEADACHES						
HEARTBURN						
HIGH BLOOD PRESSURE						
HIP PAIN						
LEG PAIN						
MENSTRUAL DISORDER						
MIGRAINES						
NECK PAIN						
NERVOUSNESS						
PINCHED NERVE						
SCOLIOSIS						
SHOULDER PAIN						
SINUS TROUBLE						
TMJ						

PRINT NAME

DATE

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The term "chiropractic", as defined in the law of this jurisdiction, is "the science and art of locating and removing without the use of drugs or surgery any interference with the transmission and expression of nerve energy in the human body by any means or methods as taught in any school of chiropractic recognized by the State Board of Chiropractic Examiners". Article 4 of Alabama Administrative code - Division 1 General Provisions.
D. The chiropractic adjustment process involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of restoring communication between the brain and the body, thus repositioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
E. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
F. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
G. Your compliance with care plans, home, and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
H. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I________________________________ 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 satisfaction. I therefore accept chiropractic care on this basis.

Signature____ Date_____________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

Signature____ Date____________________

INFORMED CONSENT FOR CHIROPRACITC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CEVICAL SPINE (NECK) ADJUSTMENTS, MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND, IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURHTER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL REVELANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE MY CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY, AND TO THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PATIENT NAME ____

PATIENT SIGNATURE____ DATE________________

IF PATIENT IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

PARENT/GUARDIAN SIGNATURE_________________________________ DATE________________

RELATIONSHIP TO MINOR/CHILD_______________________________

WITNESS SIGNATURE (OFFICE STAFF)___________________________ DATE________________

PRACTICE MEMBER INFORMATION (MUST BE COMPLETE BEFORE SERVICES CAN BE RENDERED)

NAME:____

FIRST MIDDLE LAST

ADDRESS:____

STREET (APT#) CITY STATE ZIP CODE

PHONE: Home________________Cell________________Work________________

SOCIAL SECURITY NUMBER:________________________

DATE OF BIRTH:________________________

CONTACT IN CASE OF EMERGENCY:____________________PHONE#________________

NAME OF PRIMARY INSURANCE CARRIER:____________________________

Name of insured____________________ Insured Date of Birth__ __ __ __ __ __

Insured Social Security:________________________

NAME OF SECONDARY INSURANCE CARRIER:____________________________

Name of insured____________________ Insured Date of Birth________________

Insured Social Security:________________________

Insurance Policies and Fee Schedules

- Consultation-practice member history. This service is complimentary.
- Examination (new patient or established patient)-includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $50-$75.
- Chiropractic Adjustment – The actual re-alignment of the vertebra done by hand and/or instrument. Often a sound will be heard, but if there is no auditory result it does not mean that the adjustment has not taken place. $30-$60.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Jubal Mattews, DC or Melissa Bettess, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed________________________________ Date________________