At Orr Chiropractic Center we are a wellness center where we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us detailed information of the specific stresses past and present that you have faced and will allow us to better assess the challenges to your health potential. Thank you for allowing us the opportunity to improve the quality of your life.

Patient Information

Date____/____/_____ **Patient Number: _____**

For Internal Use

Name: (First, Middle, Last) _____ Age: ___ Date of Birth: _____

Preferred Name: _____ Sex: M ___ F ___ E-Mail: _____

Address/City/State/Zip: _____

Phones: Home _____ Cell _____ Work _____ S.S. #: _____ - _____ - _____

Preferred method of contact: home / cell / work / e-mail (Circle choice)

Driver's License #: _____ Status: Minor / Single / Married / Partner / Separated / Widowed / Divorced

Spouse's Name: _____ Names & Ages of your Children: _____

_____

Appointment reminders: Text or E-Mail? _____

Employment

Employment Status: Employed / Unemployed / Retired / Part-time Student / Full-Time Student / Disabled

Employer: _____ Occupation: _____

Responsible Party (If you are over the age of 18, please indicate 'self' as responsible.)

Name: _____ Relationship to Patient: _____ Phone #: _____

Address/City/State/Zip: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone #: _____

Is Your Illness or Injury Related to any of the following?

Employment _____ Emergency _____ Auto Accident _____ State of Auto Accident _____

If Employment related, has employer been notified? Yes ___ No ___

How Were You Referred to Our Office?

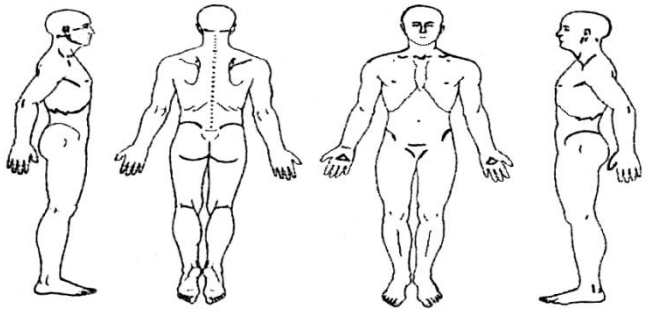
Doctor / Patient / Location / Website / Internet / Other
Please name your source: _____

Health History

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the day you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of day) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are <u>worse</u> in the (circle what applies)

-Morning -Increase during the day

-Afternoon -same all day

-Night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Cramping
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Cramping
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your conditions better:

    Ice – Heat – Rest – Stretching – Walking – Sitting – Standing – Nothing – Other _____
11. Circle the things that make your conditions worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
12. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
13. Have you been treated for this before? ____No ____Yes How long ago? _____
14. What treatment did you receive? _____
15. Results of previous treatment? ____Good ____Poor Comments _____
16. Is this condition interfering with ___ Work ___ Sleep ___ Daily Routine ___ Recreation ____ Positive Mental Attitude
17. Any other musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

Health History, Continued

Please describe your ability to perform the following activities:

U = Unable P = Painful N = Normal

Getting Out of Car		Lying down	
Walking		Twisting	
Standing Over 1 Hr		Reaching	
Sitting for over 1 hr.		Gripping	
Bending		Pushing/ Pulling	
Household chores		Sexual Activity	
Climbing stairs		Lifting	
Kneeling/Stooping		Changing position	
Personal Grooming		Exercising	
Sleeping		Carrying	

Please check & fill in the appropriate boxes:

Smoking		Packs/ Day	
Drinking		Alcohol/ Day	
Coffee		Cups/ Day	
Water		Glasses/ Day	
Pop		Cans/ Day	
Sleep		Hours/ Night	

List any vitamins or supplements you take:

List any medications you are taking and why: (prescription and non-prescription):

Please list all of the operations, procedures, fractures, dislocations & spinal taps:

Please list your 3 most significant traumas, this includes emotional, physical or chemical:

Do you exercise? If Yes, describe frequency and type
(Example: Yoga 1 time a week for 30 min and Jog 3 times a week for 45 min each time.)

Which best describes your stress level? None Minimal Moderate Tremendous

Do you consider yourself: Underweight Overweight Just Right

Nutrition & Diet

My Diet Includes		Restriction		Specific Food Restriction			
Mixed food diet (animal & vegetable sources)		Salt		Soy		Dairy	
Vegetarian		Fat		Corn		Wheat	
Vegan		Starch/Carbohydrate		All Gluten		Eggs	
		Total Calorie Intake					

Eating Habits

Skip Breakfast		Eat constantly whether Hungry or not	
Two Meals a Day		Generally eat on the run	
One Meal a Day		Add salt or sugar to food	
Graze (frequent small meals)			

Therapies

What types of therapy have you tried? Diet Modification_____Vitamins/Minerals_____Herbs_____Chiropractic_____

Fasting_____Conventional Drugs_____Homeopathy_____Acupuncture_____Other (Please Explain)_____

_____

Health History, Continued

Family History – Check all that apply Did your family have any of the following … Place an M for Mother, F for Father, B for Brother & S for Sister							
High Blood Pressure		Asthma		Ulcer or Stomach Problems		Thyroid Disease	
Heart Disease/ Attack		Diabetes		Stroke		Circulation Problems	
Emphysema		Kidney Disease		Arthritis-Rheumatism		Cancer	
Seizures/ Convulsions		Pacemaker		Mental Illness		Osteoporosis	
HIV Positive		Headaches		Back Pain			

Personal Health History – Check All that Apply									
AIDS/HIV		Cataracts		Goiter		Multiple Sclerosis		Rheumatic Fever	
Alcoholism		Chemical		Gout		Mumps		Scarlet Fever	
Allergies		Dependency		Heart Disease		Osteoporosis		Scoliosis	
Anemia		Chicken Pox		Hepatitis		Pacemaker		Stroke	
Anorexia		Colic		Hernia		Parkinson's Disease		Suicide Attempt	
Appendicitis		Depression		Disc Disease		Pleurisy		Thyroid Problems	
Arthritis		Diabetes		High Cholesterol		Pneumonia		Tonsillitis	
Asthma		Ear Infection		Kidney Disease		Polio		Tuberculosis	
Bleeding Disorders		Eczema		Liver Disease		Prostate Problems		Tumors, Growths	
Bronchitis		Emphysema		Measles		Prosthesis		Typhoid Fever	
Bulimia		Epilepsy		Migraine Headaches		Psychiatric Care		Ulcers	
Cancer		Glaucoma		Mononucleosis		Replaced Hip or knee		Sexually Transmitted Disease	
						Rheumatoid Arthritis		Whooping Cough	
Other:									

Health History, Continued

	C = Constant F = Frequent		C = Constant F = Frequent		C = Constant F = Frequent
General Symptoms		**Gastro-Intestinal**		**Skin or Allergies**	
Dizziness/ Fainting		Belching Gas		Boils or Skin Eruptions	
Depression/ Moodiness		Constipation		Bruising Easily	
Fatigue		Diarrhea		Hives or Itching	
Headache		Hemorrhoids			
Loss or Difficulty Sleeping		Frequent Nausea		**Cardio-Vascular**	
Weight Change (+/-)		Abdominal Pain		High Blood Pressure	
Nervousness		Appetite Increase/ Decrease		Low Blood Pressure	
Night Sweats		Vomiting		Poor Circulation	
Numbness Arms/ Legs/ Hands		Excessive Thirst		Rapid of Slow Pulse	
Crave Sweets/ Salts		Heartburn/ Indigestion		Swelling Ankles/ Feet/ Legs	
Cold/ Tingling Extremities		Black/ Bloody Stool		Varicose Veins	
		Difficult Chewing/ Clicking			
Eye/ Ear/ Nose/ Throat		Acid Reflux		**Genito-Urinary**	
Mouth Sores				Bed Wetting	
Earache		**Respiratory**		Blood in Urine	
Ear Ringing		Chest Pain		Frequent/ Painful Urination	
Frequent Colds		Chronic Cough		Inability to Control Urine	
Hoarseness		Difficult Breathing		Infertility	
Absence of Taste					
Absence of Smell		**Muscles & Joints**			
Vision Trouble		Walking Difficulty			
Sinusitis		Hernia			
Sore Throat		Tremors/ Twitching			
Dental Problems		Joint Pain With Stiffness			
Hearing Difficulties		Cold/ Heat Intolerance			
For Women Only				**For Men Only**	
Excessive Menstrual Flow				Benign Prostatic Hyperplasia (BPH)	
Hot Flashes		Breast Implants	Yes or No		
Irregular Cycle				Prostate Cancer	
Painful Periods				Decreased Sex Drive	
Fibrocystic Breasts				Sexual Dysfunction	
Fibroids/ Ovarian Cysts					
Decreased Sex Drive	Yes or No				
Pregnant at this time	Yes or No				
Past Pregnancies Normal	Yes or No				
Miscarriages	Yes or No	If yes, how many?			
Age of First Menses					
Date of Last Menses					
Taking Birth Control	Yes or No	If yes, what type?			

My Personal Health Goals

- ☐ Have more energy
- ☐ Be stronger/More muscle tone
- ☐ Have more endurance
- ☐ Increase sex drive
- ☐ Lose weight
- ☐ Improve Complexion/Skin
- ☐ Have stronger & healthier nails/ Teeth/Hair
- ☐ Sleep better
- ☐ Get rid of allergies
- ☐ Feel more motivated
- ☐ Improve memory/Concentration/Focus
- ☐ Do better on tests in school/Job performance
- ☐ Be free of pain
- ☐ Improve moods
- ☐ Build better immune resistance to infections
- ☐ Reduce risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)
- ☐ Not be dependent on over-the-counter medications (e.g., aspirin, ibuprofen, anti-histamines, sleeping aids etc.)
- ☐Other goals not listed above:

_____

_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Orr Chiropractic Center LLC**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only *(Circle one below)*

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.

Consent to Evaluate and Treat 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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on:
Home answering machine? Yes [ ] No [ ] Cell phone voicemail? Yes [ ] No [ ]

HIPAA Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

PATIENT FINANCIAL/OFFICE POLICY

1. **PAYMENT** – is due at time of service, unless other arrangements have been made in writing (worker's compensation or letter of protection from attorney).
2. An **INSURANCE CONTRACT** is between the patient and patient's insurance company; therefore, the patient is responsible for all fees not covered by their policy. Our office does not guarantee that your insurance company will reimburse.
3. In **DIVORCE** situations, the parent who brought the child in is responsible for payment of the bill.
4. Patients involved in **LITIGATION (Lawsuits)** are responsible for their services at the time services are rendered. Patients involved in a personal injury case must pay the outstanding balance in full within six months after the case has been closed. Personal injury accounts will go to collections with 35% being added on for collection expenses if the account is not paid after six months.
5. We reserve the right to **BILL FOR MISSED APPOINTMENTS**.
6. **RETURNED CHECKS** will be recovered by a check recovery company. Costs will be incurred by the patient.
7. **ACCOUNTS RECEIVABLE**
   a. All overdue accounts are subject to a 1.5% interest charge each 30 days; minimum $1.50
   b. Collection fees in the amount of 35% of the total bill plus any and all charged by a collection service or attorney for this account are the patient's responsibility. Accounts will be turned over to the collection service after 90 days and no payment has been received.
8. **PERSONAL CLEANLINESS IS REQUESTED DUE TO THE INTERPERSONAL NATURE OF THIS WORK.**
9. **SMOKING IN THE OFFICE IS PROHIBITED**.

I, hereby, authorize the doctor to examine and treat my condition as she/he deems appropriate through the use of Chiropractic health care, therapy, and nutritional supplementation. I give authority for these procedures to be performed. It is understood and agreed the amount paid the doctor for X-rays is for examination only and the x-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient is in this office. The patient agrees that he/she is responsible for the costs incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE THE SAME. THIS FORM IS COMPLETE TO THE BEST OF MY ABILITY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES AND FEES.

(**If** the patient is a minor, permission is hereby given by me to the Doctors of this office and whomever they designate to assist in the care of the patient. I am his/her legal guardian.)

PATIENT NAME _____

PATIENT or GUARDIAN SIGNATURE_____

DATE_____