# HEALTH PROFILE

**Thank you for choosing Cultivate Health Chiropractic. We look forward to your journey to health and healing from the inside, out. To get started, please complete the following information:**

Patient Name _____ Date of Birth_____/_____/_____ Age_____

Current Date _____/_____/_____ Circle One: MALE / FEMALE Email _____

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____) - _____ - _____ Cell (_____) - _____ - _____ Cell Provider _____

Occupation _____ Employer _____

Circle One: SINGLE / MARRIED / DIVORCED / WIDOWED

Spouse's Name _____

Children's Name, Age, and Gender _____

_____

Emergency Contact _____ Phone: (_____) - _____ - _____ Relationship _____

Who may we thank for referring you? _____

Is there anyone else in your family who could benefit from gentle, specific chiropractic care?

_____

# PLEASE LIST YOUR MAJOR HEALTH CONCERNS BELOW:

| LIST HEALTH CONCERN | WHEN DID IT START? | DID THE PROBLEM BEGIN WITH AN INJURY? | ARE THE SYMPTOMS CONSTANT OR ON/OFF? | RATE SEVERITY 1 = MILD 10 = SEVERE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you ever seen a doctor for any of these conditions? YES / NO

If so, which conditions and when? _____

Primary Care Physician _____ Physician's Office _____

Were you advised to restrict activities by any other health care provider? YES / NO

Are these conditions related to a work or auto accident? YES / NO

Have you ever seen a chiropractor before? YES / NO

| LIST HEALTH GOAL *(ex. get rid of migraines)* | DATE TO ACCOMPLISH *(December 2016)* | SIGNIFICANCE OF GOAL *(so I can return to my normal life and responsibilities without constant fear of getting a migraine)* |
|---|---|---|
| | | |
| | | |

# CIRCLE ANY PROBLEMS YOU CURRENTLY HAVE:

| | | | | |
|---|---|---|---|---|
| Dizziness | Migraines | Numbness | Reflux | ADD/ADHD |
| Headaches | Bladder Issues | Heart Disease | Ulcers | Arm Pain |
| Vertigo | Chronic Sinus | Sciatica | Kidney Problems | Nervousness |
| Ear Infections | Throat Issues | Lupus | Stomach Issues | Liver Disease |
| Nausea | Thyroid | Heart Disorders | Infertility | Shoulder Pain |
| TMJ | Asthma | Chest Pain | Epilepsy | Chronic Fatigue |
| Neck Pain | Menstrual Issues | Mid Back Pain | Disc Problems | Low Back Pain |

Other _____

**Circle which daily activities are being restricted by your health concerns:**

RECREATION / EXERCISE / HOBBIES / HOUSE CHORES / WORK / DRIVING / FAMILY TIME

| What makes your symptoms worse? | What makes your symptoms better? |
|---|---|
| | |

# CIRCLE ANY CONDITION YOU NOW HAVE OR HAVE HAD:

| | | | |
|---|---|---|---|
| Stroke | Spinal Surgery | Seizures | Diabetes |
| Cancer | Heart Disease | Scoliosis | Back Surgery |

List all surgical operations and the year in which they occurred: _____

_____

List all bone fractures and the year in which they occurred: _____

_____

List ALL prescription and over the counter medications you are currently taking: _____

_____

Do you smoke? YES / NO  If so, how often? DAILY / WEEKENDS / OCCASIONALY

How often do you exercise? DAILY / 2-3 TIMES A WEEK / OCCASIONALY / NEVER

# INFORMED CONSENT FOR CHIROPRACTIC 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 most rare complications associated with chiropractic care occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be 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 further 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 relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the Doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

**PRINT PRACTICE MEMBER'S NAME HERE**_____

**PRACTICE MEMBER'S SIGNATURE**_____

**DATE** _____

# WRITTEN CONSENT FOR A CHILD/MINOR

*If this health profile is for a minor/child, please complete the following:*

**NAME OF PATIENT WHO IS A CHILD / MINOR** _____

I authorize Dr. Jessica Bradburn and all Cultivate Health Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform Chiropractic adjustments to my child/minor.
As of this date, I have legal right to select and authorize health care services for my Child/Minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Cultivate Health Chiropractic.

**GUARDIAN SIGNATURE** _____

**GUARDIAN'S RELATIONSHIP TO CHILD/MINOR** _____

**DATE**_____

**WITNESS SIGNATURE (OFFICE STAFF)** _____

# 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 point regarding chiropractic care and the services that are offered through this clinic:

1. 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.
2. 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 normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning 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.
4. 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.
5. 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.
6. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
7. 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.

By my signature below, 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 your 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 to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

**SIGNATURE** _____ **DATE**_____

# PRACTICE MEMBER INFORMATION

**(Must be completed before services can be rendered)**

Patient Name _____ Date of Birth ____/____/_____

Social Security Number _____-____-_____

Marital Status: SINGLE / MARRIED / DIVORCED / WIDOWED

Home Phone (_____)-_____-_____ Cell (_____)-_____-_____

Name of Primary Insurance Carrier: _____

Name of Insured: _____ Insured Date of Birth: ____/____/_____

Insured Social Security Number: _____-____-_____

Name of Secondary Insurance Carrier: _____

Name of Insured: _____ Insured Date of Birth: ____/____/_____

Insured Social Security Number: _____-____-_____

# INSURANCE POLICIES AND FEE SCHEDULE

**Consultation:** includes practice member history. This service is complimentary.

**Assessment (new or established practice member):** 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. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.

# RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Jessica Bradburn, 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.

**SIGNATURE** _____ **Date**_____