Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female Other \_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact:  Call  Text  Email

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language:  English Other \_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Job Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_\_\_\_\_\_

Other Doctors seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had the same or similar symptoms before?  Yes  No Date of prior condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List chief symptoms in order of severity:

(1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Family History**: *(Circle all that apply)* Unsure of any

(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arthritis: Self Parent Sibling Grandparents

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer:  Self Parent Sibling Grandparents

Have you had chiropractic care before?  Yes  No Diabetes: Self Parent Sibling Grandparents

Date: \_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Diseases: Self Parent Sibling Grandparents

May we move forward our findings to your doctor? Yes  No Hypertension: Self Parent Sibling Grandparents

Previous Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke: Self Parent Sibling Grandparents

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid: Self Parent Sibling Grandparents

Allergies (Medicine, Food, Environment) \_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No known drug allergies or allergies Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications (Including Vitamins and Supplements) and **what they are for**? (bring in a list as well)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle what apply:

Do you take blood thinners (heparin, coumadin, warfarin), steroids?  Yes  No

Do you have any family history of; rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke?  Yes  No

Check all symptoms that apply to you:

Headache Tingling/numbness in arms/hands Chest pain Unexplained weight loss

Neck Pain/Stiffness Tingling/numbness in legs/toes Knee pain Fatigue

Back pain/Stiffness Loss of balance/dizziness Hip pain Night Sweats

Shoulder Pain Shortness of breath Fever Blood in Urine

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Night Pain Pain unrelieved by rest

For women: Are you pregnant? Yes No Are you taking birth control? Yes No

****

**Review of Systems-** (check box if you have had trouble with any of the following)

** I currently do not have or have had in the past any of these conditions**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cardiovascular** | Past | Present |  | **Respiratory** | Past | Present |  | **Allergic/Immunologic** | Past | Present |
| Poor Circulation |  |  | Asthma |  |  | Hives |  |  |
| Hypertension |  |  | Tuberculosis |  |  | Immune Disorder |  |  |
| Aortic Aneurysm |  |  | Short Breath |  |  | HIV/AIDS |  |  |
| Heart Disease |  |  | Emphysema |  |  | Allergy Shots |  |  |
| Heart Attack |  |  | Cold/Flu |  |  | Cortisone Use |  |  |
| Chest Pain |  |  | Cough |  |  |  | | |
| High Cholesterol |  |  | Wheezing |  |  | **Ear, Nose, and Throat** | Past | Present |
| Pace Maker |  |  |  | | | Difficulty Swallowing |  |  |
| Jaw Pain |  |  | **Eyes** | Past | Present | Dizziness |  |  |
| Irregular Heartbeat |  |  | Glaucoma |  |  | Hearing Loss |  |  |
| Swelling of legs |  |  | Double Vision |  |  | Sore Throat |  |  |
|  | | | Blurred Vision |  |  | Nosebleeds |  |  |
| **Genitourinary** | Past | Present |  | | | Bleeding Gums |  |  |
| Kidney Disease |  |  | **Psychiatric** | Past | Present | Sinus Infections |  |  |
| Burning Urination |  |  | Depression |  |  |  | | |
| Frequent Urination |  |  | Anxiety |  |  | **Gastrointestinal** | Past | Present |
| Blood in urine |  |  | Stress |  |  | Gall Bladder Problems |  |  |
| Kidney Stones |  |  | PTSD |  |  | Bowel Problems |  |  |
| Lower Side Pain/Flank |  |  | **Endocrine** | Past | Present | Constipation |  |  |
|  | | | Thyroid |  |  | Liver Problems |  |  |
| **Neurologic** | Past | Present | Diabetes |  |  | Ulcers |  |  |
| Stroke |  |  | Hair Loss |  |  | Diarrhea |  |  |
| Seizures |  |  | Menopausal |  |  | Nausea/Vomiting |  |  |
| Head Injury |  |  | PMS |  |  | Bloody Stools |  |  |
| Concussion |  |  |  | | | Poor Appetite |  |  |
| Brain Aneurysm |  |  | **Musculoskeletal** | Past | Present |  | | |
| Numbness |  |  | Gout |  |  | **Hematologic** | Past | Present |
| Severe Headaches |  |  | Arthritis |  |  | Hepatitis |  |  |
| Pinched Nerves |  |  | Joint Stiffness |  |  | Blood Clots |  |  |
| Parkinson’s |  |  | Muscle Weakness |  |  | Cancer |  |  |
| Carpal Tunnel |  |  | Osteoporosis |  |  | Bruising |  |  |
| Vertigo |  |  | Broken Bones |  |  | Bleeding |  |  |
| **Constitutional** | Past | Present | Joints Replaced |  |  | Fever, Chills |  |  |
| Weight Loss/Gain |  |  | Neck Pain |  |  | Sweating |  |  |
| Low Energy Level |  |  | Low Back Pain |  |  | Varicose Vein |  |  |
| Difficulty Sleeping |  |  | Upper Back Pain |  |  |  |  |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History & Assessment**

**VITALS** Last Known Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY** (Check all that apply to you)

**Caffeine use:** **Drink Alcohol:**

Occasional Often Never How much \_\_\_\_\_\_\_\_\_\_\_\_ Occasional Often Never

How much on typical day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise:**

Occasional Often Never How much \_\_\_\_\_\_\_\_\_\_\_\_ **Tobacco Use:** Type: \_\_\_\_\_\_\_\_\_

Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current everyday Occasional Former Never

Packs/day \_\_\_\_\_\_\_ Smoking start date \_\_\_\_\_\_\_\_\_

**Recreational Drug Use**: Smoking end date \_\_\_\_\_\_\_\_\_\_\_

Occasional Often Never

**Soft Drinks (Soda/Pop)** **Energy Products or Over the Counter Stimulants**

Occasional Often Never How much \_\_\_\_\_\_\_\_\_\_\_\_ Occasional Often Never

**Diet/Healthy Eating ranking** **Water**

Bad Okay Could be Better Good Great Occasional Often Never How much \_\_\_\_\_\_\_

**Processed, Packaged, & Restaurant Food Fresh & Homemade Foods**

Occasional Often Never Occasional Often Never

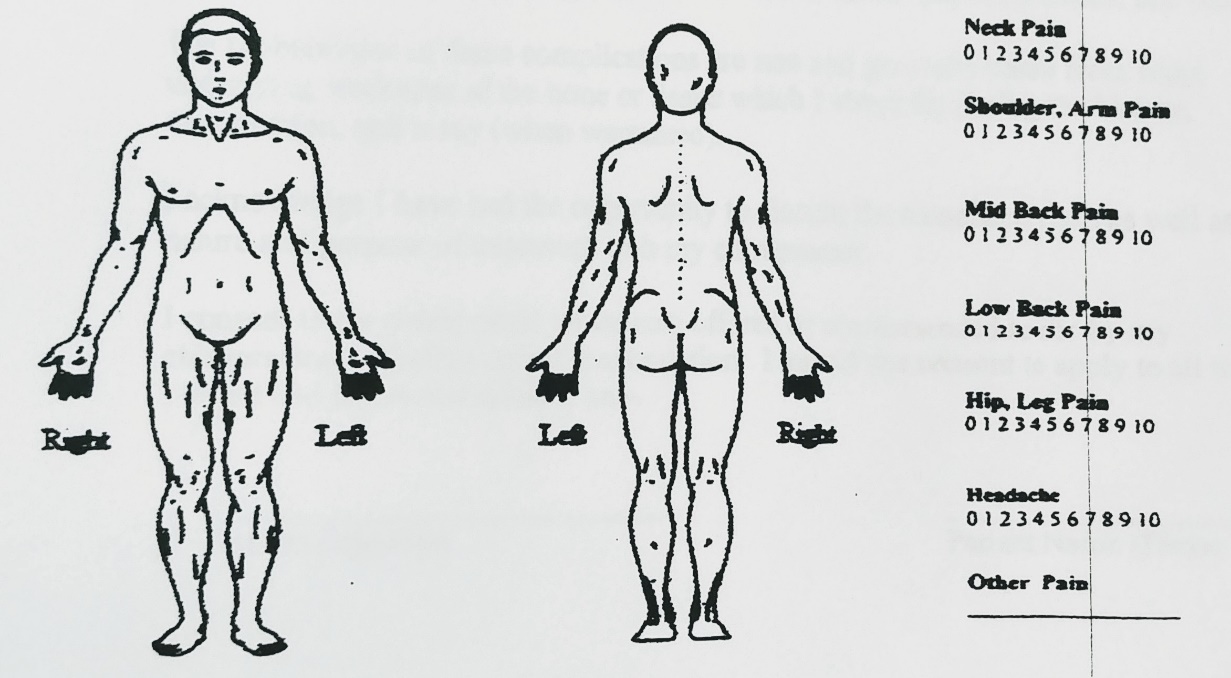
How many hours of sleep do you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you wake up because of pain? \_\_\_\_\_\_\_\_\_\_\_

Did you have sleep issues before\_\_\_\_\_\_\_\_\_\_\_\_\_\_? Do you have a hard time falling asleep because of pain? \_\_\_\_\_\_\_\_\_\_\_

Do you wear: Arch supports Orthotics Heel lifts None

Time of day when pain is worst: \_\_\_\_\_ Morning \_\_\_\_Afternoon \_\_\_\_\_Evening

Does this pain radiate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Is the pain: No pain Mild Moderate Severe**

**** Please circle on the scale from, no pain to severe pain, and what you feel with this condition. Mark the type of pain below and where it pertains to the area on the left.

**No pain Mild Moderate Severe**

**No pain Mild Moderate Severe**

**No pain Mild Moderate Severe**

**No pain Mild Moderate Severe**

**Type of pain**:

**No pain Mild Moderate Severe**

Stiffness \_\_\_\_\_\_\_

Burning \_\_\_\_\_\_\_

**No pain Mild Moderate Severe**

Numb/Tingling \_\_\_\_\_\_\_

Sharp\_\_\_\_\_\_\_\_

Soreness/Achy \_\_\_\_\_\_\_\_

****

**Activities of Daily Living/Symptoms/Medications**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                                     File#\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daily Activities:  Effects of Current conditions On Performance**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bending |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Concentrating |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Computer work |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Gardening |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Playing sports |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Recreation activities |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Shoveling |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Sleeping |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Watching TV |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Carrying |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Dancing |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Lifting |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Pushing |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Rolling over |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Sitting |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Standing |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Working |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Climbing |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Doing Chores |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Driving |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Sexual activity |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Reading |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Running |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Sitting to Standing |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |
| Walking |  No Effect | Painful (But functional) | Painful (Can’t Do) | Unable to perform |

**Health Insurance**

Policyholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Bull Family Chiropractic and their affiliated providers for any reason, I will be responsible for payment of my entire outstanding balance.

I hereby request, consent and authorize Bull Family Chiropractic and their affiliated providers to administer treatment, physical examination, chiropractic care, therapeutic rehabilitation, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. In particular, soreness is the most common symptom to feel after chiropractic care. If symptoms progress further than 72 hours, please consult your chiropractor. Some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques, but these are rare. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures; There are reported cases of stroke associated with visits to medical doctors and chiropractors. The scientific evidence and research does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. Essentially, a stroke is already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote; There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment; Some electrical therapies offered by doctors of chiropractic can cause burns or skin irritation; however, this reported cases are infrequent.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent. I have had my questions answered to my satisfaction. I also understand that there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including but not limited to medication and/or surgery.

I further authorize them to disclose all or any part of my (patient’s) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic’s charge, including, and not limited to hospital or medical services companies, insurance companies, or the patient’s employer.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

**Patient’s or Guardian Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

****

**Credit balances:**

\*\*\*Any credit balance resulting from a patient’s payment will be applied to other household members of the patient or credited to future appointments. If a patient’s account becomes inactive for a period of 12-months, then credit on account will be refunded automatically. If the balance is less than $40.00, it must be requested by patient.\*\*\*

**HIPAA Authorization/ Privacy Practices**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I acknowledge that in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that I have the right to revoke this consent, in writing, except to the extent that Bull Family Chiropractic (BFC) has taken action in reliance on this consent.

With this consent, BFC can call me at home or an alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations (TPO), such as appointment reminders, obtaining insurance information, billing, and any calls pertaining to my clinical care. Bull Family Chiropractic also has my consent to mail any items that assist the practice in carrying out TPO, such as appointment cards, statements, and insurance information. I am consenting to BFC, the use of my Protected Health Information (PHI) to carry out the TPO.

I also understand that BFC will uphold the privacy of my medical records unless this information is requested to be released by myself or someone who I have given permission to access my records. I am also fully aware that Bull Family Chiropractic will not share my medical records with anyone without an authorization, except in the event of an emergency or patient’s condition that deems the situation medically necessary.

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_

By signing my name below, I acknowledge my understanding of the terms of this agreement. This authorization shall supersede any prior written authorization I have made regarding the use, disclosure, and release of my medical information. This authorization will expire 2 years from the date it is signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Personal Representative**

**Photo/Video/Social Media Consent**

We are PROUD of our patients and the progress they make while under our care! There’s nothing we enjoy more than CELEBRATING our patients’ successes along with them. If the moment arises, we would love to share your name, photo, video, story, or progress on our Social Media page(s) or website in the interest of showing others that “real people” visit our office and are smiling while they’re here – and most importantly, getting results!

**Please check the box that applies to you:**

€ Sure! You can use my picture, video, and testimonials on your Website and Social Media (i.e. Facebook, Instagram, etc.) pages, as long as I look good in it!

 No thanks! I’ll pass for now.

**WORK/AUTOMOBILE ACCIDENT QUESTIONNAIRE**

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you the Driver \_\_\_\_\_\_ Passenger (Front/Back seat)\_\_\_\_\_\_\_

Time of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speed you were travelling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other vehicle speed \_\_\_\_\_\_\_\_\_\_\_

Location of Accident: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_

Amount of damage done to vehicle: No damage/ Minimal, <$2,000/ Moderate, > $2,000 damage/ Totaled, severe damage

If total loss has occurred, what is the amount they determined the damage at? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visibility: Poor Fair Good The weather was: Snowing Raining Foggy Windy Clear Sunny

Who hit who/what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Point of Impact: Front Rear Left front Left rear Left side Right front Right rear Right side

Did you have your seatbelt/shoulder strap on? Yes No Did the airbag(s) deploy Yes No

Did you hit anything in the vehicle? Yes No

If yes, what? Airbag Armrest Center Console Dashboard Gear shift/knob Headrest Rearview mirror Roof

Rear window Seatback Side door Side window Wheel Windshield Other: \_\_\_\_\_\_\_\_\_\_\_\_

Did you see the accident coming? Yes No Does the vehicle have headrests? Yes No

Did you brace for impact? Yes No Did you lose consciousness? Yes No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_

What direction was your head in? Facing forward Turned to the right Turned to the left

Was your head injured? Yes No Other body parts injured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediately following the accident did you experience? Headaches Neck pain Low back pain (circle which ones)

Did you go to the hospital? Yes No Any transportation to the hospital? Yes No Tests done \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where you stopped at a red light or stop sign and rear ended? ­­­\_\_\_\_\_\_\_\_\_\_\_\_

Head on collision \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Another vehicle ran a stop sign or red light \_\_\_\_\_\_\_\_

Did vehicle get hit into another vehicle or tree? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Slowing down to make a stop or turn- rear ended \_\_\_\_\_\_\_\_\_\_\_

Lost control\_\_\_\_\_\_ Spun around \_\_\_\_\_\_ Rolled over

Side swiped\_\_\_\_\_\_\_\_\_\_

“T-Boned” \_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CONSENT TO TREAT A MINOR**

I (we) being the parent, guardian or custodian of the minor being \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, age \_\_\_\_\_\_, do hereby authorize, request & direct Bull Family Chiropractic and it’s doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_