Modern Health Chiropractic

Client Interview

Thanks for trusting us with your health!

First Name_____ MI __ Last Name_____ Date_____

Address _____ City_____ State__ Zip _____

Cell _____ Cell Provider _____ Email _____

Home Phone_____ Work Phone_____ Birthdate _____ Texts? Y☐ N☐

How did you discover our office? _____

Reason for consulting our office today: _____

What are your expectations for your care in this office?

_____

_____

Please list any concerns in order of importance:

1. _____ 2. _____ 3. _____

Have you seen any other professional for these concerns? Y☐ N☐

If yes, describe the treatment and any results:

_____

Please check each of the following that has ever applied to your Health

☐ Frequent sickness	☐ ADD/ ADHD	☐ School difficulties
☐ Ear infections (aching)	☐ Poor balance or coordination	☐ Stress or Anxiety
☐ Headaches	☐ Bed wetting	☐ Social fears/ problems
☐ Often unhappy/depressed	☐ Asthma/ Allergies	☐ Scoliosis/ Spinal problems
☐ X-rays or MRI	☐ Bone fracture	☐ Car accidents
☐ Spinal or head injury	☐ Falls	☐ Neurological conditions
☐ Birth Trauma (forceps, vacuum, c-section		☐ Developmental delays
☐ Sleeping issues	☐ Lack of muscle coordination	☐ Muscle weakness

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your health.

_____

_____

_____

Have you ever been to a chiropractor before? Y☐ N☐ When _____

Why did you go? _____

What were the results? _____

Why did you stop going? _____

Do you have any conditions that may alter the way in which your care is delivered?

_____

What is the quality of the following?:

Sleep _____

Diet _____

Exercise _____

Do you take any nutritional supplements, vitamins, or medications? (Please explain)

_____

Do you participate in any sports, lessons, talents, or hobbies? (Please describe)

_____

What are your most important goals for your health?

_____

Is there anything else that we need to know about you that was not addressed on this form?

_____

_____

_____

Over

Payment Policy

Payment is due at the time services are rendered. All fees will be explained before any professional services are rendered. If you have insurance you may be able to be reimbursed for part of your expenses at our office. (Muscle activation is excluded from Medicare.)

We ask that you kindly give 24 hours notice to change an appointment. Missed appointments are subject to a $20 fee for each 15 minute time period scheduled.

Policies are subject to change. You will be notified of any changes prior to implementation.

Informed Consent

It is NOT the goal of chiropractic to treat any symptom, disease, or condition. Rather, we care for the spine with the sole purpose of removing interference with and tension from the nervous system. We also employ extremity work to improve muscle and joint stability and function. Every person is better with improved neural and musculo-skeletal function and this alone justifies our care. Research studies report improved health and wellness that is consistent with the care given. However, no one can predict the specific benefits you will receive.

By my signature I give my consent Modern Health Chiropractic, LLC to use my client information and for a Doctor of Chiropractic to examine my spine and extremities. If I choose to receive Chiropractic care, my payment for such services, in addition to my signature here; will serve as acknowledgment of my permission for a doctor of chiropractic to deliver such care to me.

Privacy Notice

Your health information is private and protected by law. Your health information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations in this office. You have a right to review your office file. You may restrict all or part of your health information. Our privacy manual is available at any time for you to review, and a detailed explanation of the privacy policy is available upon request.

I have had a chance to ask questions about the privacy policy and I give my permission to Modern Health Chiropractic, LLC to disclose my protected health information in accordance with such policies.

_____ _____

Signature Date