Gaslight
FAMILY CHIROPRACTIC

2213 Wealthy Street SE, Ste 220
Grand Rapids, MI 49506
P: 616.458.2348
www.gaslightchiro.com

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

How did you hear about our office? _____

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

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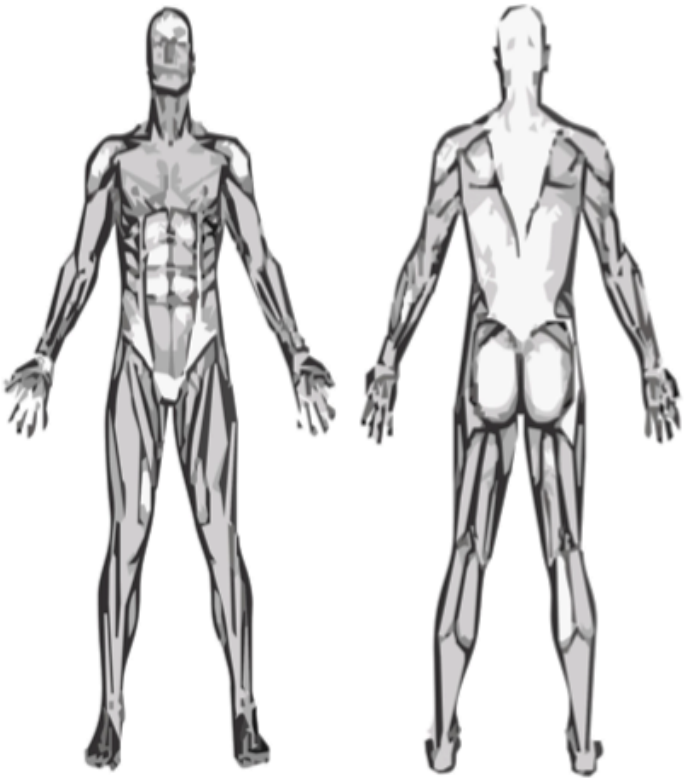
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Gaslight Family Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided (or can be provided at my request), a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Gaslight Family Chiropractic reserves the right to review the notice prior to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Gaslight Family Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

___ Accepted ___ Denied

_____

Patient Signature | Patient Printed Name | Date

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Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays (if needed), and physical therapy techniques on myself or on the patient named below for which I am legally responsible. I understand that these procedures are performed by the licensed doctors of chiropractic at this practice.

I understand that as with any health procedure, there are certain complications that may arise during a chiropractic adjustment. These complications include, but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries of the neck, leading to, or contributing to serious complications including stroke. This is a very rare occurrence (1:3,000,000 chance). We screen our patients for indications that they are a candidate for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the patient's best interest.

I have had (or will have) an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had (or understand I have the right to have) my questions answered to my satisfaction. I understand the results are not guaranteed.

_____

Patient Signature Patient Printed Name Date

Informed Consent for Therapeutic Massage

I understand the general benefits of massage, possible massage contraindications and treatment procedure have been (or will be) explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary physician for any condition that I may have. I am aware that massage scheduled infrequently has limited benefits, and it is recommended to receive massage at least one session every four to six weeks for full benefits.

I understand that the massage therapist does not diagnose any illness or disease, does not prescribe any medications and that anything said before, during, or after the session should not be inferred as such. **I understand that it is MY responsibility to communicate and give feedback regarding any pain or discomfort I may experience during the session.**

I have informed (or will inform) the massage therapist of all my known physical and medical conditions, as well as my current medications. I will keep my massage therapist up-to-date on any medication or health changes. I understand that withholding medical information could be harmful to myself, and that withholding this information removes the massage therapist from any liability.

I understand that therapeutic massage is non-sexual in nature and if the massage therapist feels threatened or harassed in any way, the session will end immediately, full payment will be made, and no future appointments will be available to me.

By signing below, I acknowledge that I have read and understand the above statements, and therefore am giving my consent for this and every therapeutic massage session at Gaslight Family Chiropractic.

_____

Patient Signature Patient Printed Name Date

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Financial & Cancellation Policies

Payments

Our clinic has established a single fee schedule that applies to all patients for each service provided. *Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic.

Please read the following and initial your preference for the method of payment on you account at this clinic. Please notify this office if the status of your insurance changes.

Private Pay: Please select either option 'A' or option 'B' on our Policy Agreement form if you are choosing to pay your account personally.
A:_____ I agree to assume all responsibility for my account, and to keep said account current by paying for services as they are rendered.
B: _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility for my account. I understand it is my responsibility to keep my account up-to-date by paying for each visit at the time services are rendered. (I will need a Health Claims Form)

Insurance Coverage

We are in-network with **Blue Cross Blue Shield** and are able to bill your services to them directly.

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. We bill services to insurance as a convenience to you. Like all types of care, coverage for chiropractic and therapeutic massage services vary between insurers and plans. Most insurance policies require the beneficiary to pay co-insurance (a percentage of the service fees), co-payment (co-pay - a flat fee per visit) and/or a deductible. We are not responsible for your insurer's final payment and benefit determinations. You may be entitled to a network or contractual discount if we are a participating provider in your health plan.
C: _____ Please initial here if you have BCBS and would like us to bill services on your behalf.

Cancellation Policy

We know that your time is valuable and will make sure to notify you as soon as possible if there is a conflict in our ability to keep your appointment as scheduled. We ask that you honor our time as well with at least 24-hour notice if you need to reschedule an appointment. **A $45.00 fee will be charged in the case of a missed visit without advanced notice.** We understand that life happens and in the case of emergency or unavoidable circumstances we will waive the fee.

_____ My initials here indicate that I have read and understand the above Cancellation Policy. I understand that all health services rendered to me and charged to my account are my personal financial responsibility and I agree to adhere to the aforementioned conditions of these financial and cancellation policies

_____

Patient Signature Patient Printed Name Date