

Innate Chiropractic
916A San Pablo Ave.
Albany, CA 94706
(510) 528-5216 Ph (510) 528-5256 Fax

PERSONAL DATA

Name _____ Date _____ Age _____ DOB _____

Home Phone # _____ Cell Phone _____ Email _____

Address _____ City _____ State _____

Zip Code _____ Driver Lic # _____ Social Security # _____

Marital Status: S M D W Occupation _____

Name of Spouse _____ Ages of Children _____

Hobbies _____

What is your major complaint? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____ What aggravates your condition? _____

Is this condition getting progressively worse? Y _____ N _____ Constant _____ Comes and goes _____

Is this condition interfering with your Work _____ Sleep _____ Daily routine _____ Other _____

Who referred you to our office? _____

Have you been under chiropractic care before? _____

Doctor's Name _____ When? _____ How long _____

What did you like about your care? _____

What did you not like about your care? _____

Reason for consulting this office: _____

The practice of chiropractic is based upon the location and the adjustment of vertebral subluxations. These spinal subluxations are caused by any stress of which your body cannot adapt. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

HEALTH HISTORY

1. Were there any problems associated with your mother's pregnancy or your birth? Please explain: _____

2. Did you have any childhood illness or injuries? Please explain: _____

3. Have you had any traumatic injuries? Please explain: _____

4. Have you had any sports injuries? Please explain: _____

5. Have you had any auto or other accidents? Please explain: _____

6. Have you had any hospitalizations or surgery? Please explain: _____

7. Are you taking any drugs now? _____ Have you taken any drugs in the past? _____ What for? _____

8. Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

9. Emotional Stress:	Heavy	Moderate	Light
Childhood	_____	_____	_____
School	_____	_____	_____
Family	_____	_____	_____
Work	_____	_____	_____
Personal Relationships	_____	_____	_____

10. Write any history or concerns you have in these areas:

Head _____

Neck _____

Arms _____

Hands _____

Shoulders _____

Back _____

Breathing _____

Stomach _____

Hips, Legs and Feet _____

Women's Menstrual issues /Other _____

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Cancellation Notice: For the first missed appointment or cancellation within 24 hr there will be no charge, for the next missed appointment or cancellation within 24 hr there will be a charge of \$20. Afterwards, the charge will be \$50. Your insurance company will not pay for missed appointments.

Initials _____

Children/Family: Once you understand that the nervous system controls and coordinates all functions of the body and subluxations interfere with the nerve flow, we expect that you would want everyone in your family checked. We have a cost-effective family program for you. We extend an opportunity for you to have your family checked at a discounted rate within 1 month of starting care.

Initials _____

Interruption of Care: In the unlikely event it is necessary to discontinue your care for any reason let us know. We will make every attempt to accommodate you and make affordable arrangements if needed.

Initials _____

Referrals: The success of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like to have invited to our office, please let us know.

Initials _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient for whom I am legally responsible) by the doctors of chiropractic named above, or any others working at this office.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise such judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment of my present condition and for my future condition(s) for which I seek treatment.

Signature _____

Date _____

PRIVACY POLICY

I have also read and received a copy of the HIPPA Privacy Statement provided by this office.

Initial _____

PAYMENT AND INSURANCE INFORMATION

If you are here because you have been involved in an automobile accident, a personal injury accident, or an on-the-job injury, please fill out the accident form.

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE!

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that **Innate Chiropractic** will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give **Innate Chiropractic** power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature _____

Date _____

Relationship to patient: SELF SPOUSE PARENT GUARDIAN

Insurance Company Name _____

Name of Insured _____