

**HEALING HANDS Chiropractic and Massage**

6005 W. Miller Rd., Suite 6  
Swartz Creek, Michigan 48473  
healinghandschiropractic.org  
(810) 630-0555

**BASIC CONFIDENTIAL HISTORY**

Mr., Mrs., Ms., Dr. (Circle one)

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

\_\_\_\_\_  
First M.I. Last

\_\_\_\_\_  
Address City State Zip

Primary Phone: \_\_\_\_\_ Hm/Cell Secondary Phone: \_\_\_\_\_ Hm/Cell

Work Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_ Status: M S D W

Your Occupation: \_\_\_\_\_

Your Place of Employment and Address: \_\_\_\_\_

Spouse's or Significant Other's Name : \_\_\_\_\_ Birth Date: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Spouse's Place of Employment and Address: \_\_\_\_\_

# of Children: \_\_\_ Name and Age of Children: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

Responsible Billing Party: \_\_\_\_\_

Medicare: Yes/No Health Insurance Company Name: \_\_\_\_\_

Other and/or 2nd Insurance Name: \_\_\_\_\_ \*Please bring Health Insurance Card(s) to front desk.

Who referred you to this office? \_\_\_\_\_

What influenced you to seek treatment at this office? \_\_\_\_\_

**Main Complaint/Problem:** \_\_\_\_\_

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

Please go to the next page

## Healing Hands

Please rate the severity of the items that apply to your past or present health on a scale from 1-10.  
Leave any that **do not apply** to you **blank**.

**For example:**

You had migraines when you were little and you are still having them now. In the past they were a 5 and now they are a 10. Rate these.

<u>Past</u>	<u>Current</u>	<u>Condition</u>
5	10	Migraines
3	10	PMS

If the condition does not apply to you, do not rate it. Leave it blank.

<u>Past</u>	<u>Current</u>	<u>Condition</u>
_____	_____	Pneumonia
_____	_____	Asthma

<u>Past</u>	<u>Current</u>	<u>Condition</u>	<u>Past</u>	<u>Current</u>	<u>Condition</u>
_____	_____	Vision Problems	_____	_____	Swelling of the Ankles
_____	_____	Anaphylactic Reactions	_____	_____	Poor Circulation
_____	_____	PKU	_____	_____	Varicose Veins
_____	_____	Cystic Fibrosis	_____	_____	Blood Clots
_____	_____	Multiple Sclerosis	_____	_____	Rapid Heart Rate
_____	_____	Myathenia Gravis	_____	_____	Slow Heart Rate
_____	_____	Polio	_____	_____	Irregular Heart Rate
_____	_____	Epilepsy	_____	_____	High Blood Pressure
_____	_____	Epstein Barr	_____	_____	Low Blood Pressure
_____	_____	Lupus	_____	_____	Chest Pains
_____	_____	Limes Disease	_____	_____	Heart Attack(s)
_____	_____	Hypoglycemia	_____	_____	Nausea
_____	_____	Diabetes	_____	_____	Vomiting
_____	_____	Convulsions	_____	_____	Constipation
_____	_____	High Fever	_____	_____	Diarrhea
_____	_____	Fainting	_____	_____	Stomach Pain
_____	_____	Hives	_____	_____	Digestion Trouble
_____	_____	Earaches	_____	_____	Hemorrhoids
_____	_____	Deafness	_____	_____	Gall Bladder Problems
_____	_____	Ear Discharge	_____	_____	Recent Bowel Changes
_____	_____	Ringing Ears	_____	_____	Difficult Urination
_____	_____	Frequent Colds	_____	_____	Painful Urination
_____	_____	Hay Fever	_____	_____	Frequent Urination
_____	_____	Nose Bleeds	_____	_____	Blood in Urine
_____	_____	Gum Troubles	_____	_____	Bed Wetting
_____	_____	Tonsillitis	_____	_____	Abnormal Discharges
_____	_____	Hoarseness	_____	_____	Impotence
_____	_____	Enlarged Glands	_____	_____	Infertility
_____	_____	Throat Infections	_____	_____	Periods
_____	_____	Chronic Cough	_____	_____	Breasts
_____	_____	Excessive Phlegm	_____	_____	Ovaries
_____	_____	Coughing Up Blood	_____	_____	Uterus
_____	_____	Asthma	_____	_____	Menopausal Symptoms
_____	_____	Bronchitis	_____	_____	Miscarriages
_____	_____	Wheezing	_____	_____	Presently Pregnant
_____	_____	Difficulty in Breathing	_____	_____	Presently Nursing
_____	_____	Pneumonia	_____	_____	Problems W/ Pregnancy
_____	_____	Tuberculosis	_____	_____	PMS
_____	_____	Emphysema	_____	_____	PID
_____	_____	Pleurisy	_____	_____	Endometriosis

**Please Take Your Time**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
_____	_____	Tension
_____	_____	Neck Pain
_____	_____	Pain in Middle of Back
_____	_____	Pain Radiating in Arms
_____	_____	Shoulder Pain
_____	_____	Rotator Cuff Injury
_____	_____	Tennis Elbow
_____	_____	Wrist Pain
_____	_____	Low Back Pain
_____	_____	Hip Pain
_____	_____	Pain Radiating in Legs
_____	_____	Knee Pain
_____	_____	Ankle/Foot Pain
_____	_____	Joint Pain
_____	_____	Arthritis
_____	_____	Gout
_____	_____	Itching
_____	_____	Rashes
_____	_____	Dryness
_____	_____	Psoriasis
_____	_____	Fatigue
_____	_____	Sinus Problems
_____	_____	Nasal Drainage
_____	_____	Headache
_____	_____	Eye Pain
_____	_____	Migraine

**Healing Hands**

If at any time you do not have the necessary room to complete any of the questions, please feel free to use the back of this questionnaire.

Please check any of these body work modalities you have experienced. In the Enjoyed space please rate your experience on a scale of 1 to 10. 1 being the least and 10 being enjoyed very much.

Had	Enjoyed	Had	Enjoyed	Had	Enjoyed
_____	_____	_____	_____	_____	_____
	Acupuncture		Esoteric		Relaxation Massage
_____	_____	_____	_____	_____	_____
	Acupressure		Hot Rock Massage		Reiki
_____	_____	_____	_____	_____	_____
	Chiropractic		Lymphatic Drainage		Scar Tissue Release
_____	_____	_____	_____	_____	_____
	Colonics		Myofacial Release		Swedish Massage
_____	_____	_____	_____	_____	_____
	Cranial Sacral		Polarity		Therapeutic Massage
_____	_____	_____	_____	_____	_____
	Deep Tissue Massage		Reflexology		3-in-1 Concepts

List **ANY** Auto Injury you ever had. (even if you think they were minor) Age \_\_\_\_\_ Daytime or Nighttime

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

Have you ever had any Traumatic Injuries? If so, what age were you and please explain what happened? \_\_\_\_\_

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

Have you ever had surgery? Why? \_\_\_\_\_

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

Have you ever had a serious Illness? Explain. \_\_\_\_\_

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

Can you tell us what kind of birth you were? Normal/C-Section/Breach-Posterior/Forceps/Suction

If you had a traumatic birth describe: \_\_\_\_\_

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

Do you have any allergies? If so, how long have you had them? \_\_\_\_\_

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

Are you currently taking any medications or receiving any treatment for any health related issues? If so, which medications and who is your treatment provider(s)? \_\_\_\_\_

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

Are you currently taking any Vitamins, Nutritional Supplements, Homeopathic Remedies, Herbs, or any other Alternative Therapies? If so, please explain. \_\_\_\_\_

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

Please go to the next page

**Healing Hands**

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Have you ever taken or had any problem with chemically dependent drugs/contraband/controlled substances/or alcohol? If so, please explain. \_\_\_\_\_

Do You Wear Glasses \_\_\_\_\_ Contacts \_\_\_\_\_ Lens Implants \_\_\_\_\_

Do you have Dentures \_\_\_\_\_ Partial Plates \_\_\_\_\_ Bridges \_\_\_\_\_ Crowns \_\_\_\_\_ Root Canals \_\_\_\_\_

Have you ever had your amalgam fillings removed and replaced? If so what were they replaced with and when? \_\_\_\_\_

Please explain ALL allergies chemical and/or drug sensitivities if applicable. \_\_\_\_\_

**ACTIVITIES:** Do you exercise? If so, please explain the type of activity you do: \_\_\_\_\_

Do you engage in any leisure activities? If so, please explain the type of leisure activities you do. \_\_\_\_\_

**ADDITIONAL:** Do you have anything you feel must be addressed to enable us to assist you better? \_\_\_\_\_

**Authorization of Services**

I authorize and request the performance of Chiropractic Treatment for myself and/or my minor child. After discussing my condition with me, I give consent for any advisable and necessary procedures including spinal manipulations, essential oils, flower essences, homeopathy and natural vitamin supplements to be administered by the attending physician, or staff, for the purpose of determining the best possible treatment for me and assisting my body in regaining a healthier state of being.

I understand that Massage Therapist do not diagnose illness, disease or any other physical or mental disorder. As such, they do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that if I believe I have a serious medical condition I should seek the advise of a physician.

I recognize that all physicians and/or therapist working in this office must be aware of exiting physical conditions. My signature below will verify that all information I have listed is to the best of my knowledge, true, complete, and correct. I have stated all my known medical conditions and agree to take it upon myself to keep everyone involved with my care updated with any changes in my physical health

Patient Signature: \_\_\_\_\_ Parent/Guardian Signature (if patient is a minor) \_\_\_\_\_

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

**Cancellation Policy**

Please call this office as soon as possible when you are unable to make a scheduled appointment.

Although we recognize emergencies do arise, we ask that you please give consideration for others who may need an appointment you can not make

Please provide our office with 24 hour notice of cancellation.

**If 24 hours notice is not given you may be billed for your missed appointment.**

Initials: \_\_\_\_\_

### Healing Hands Chiropractic and Massage HIPPA Policy

Consent for Purposes of Treatment, Payment and Healthcare Operations

My "private, personal and protected health information" means health information, combined and including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical, mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Healing Hands Chiropractic and Massage for the purpose of diagnosing, recommending or providing treatment to me, obtaining payment for my health care bills from a third party or to conduct health care operations of Healing Hands Chiropractic and Massage. I understand that Dr. Melinda S. Benn, the clinic staff, therapist and any associated business partners may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information to the above stated purposes with my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Healing Hands Chiropractic and Massage is not required to agree to the restrictions that I may request. However, if Healing Hands Chiropractic and Massage agrees to a restriction that I request, the restriction is binding on Healing Hands Chiropractic and Massage, Dr. Melinda S. Benn, and her staff.

I understand I have a right to review Healing Hands Chiropractic and Massage's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Healing Hands Chiropractic and Massage. The Notice of Privacy Practices for Healing Hands Chiropractic and Massage is provided on request at the front desk. This Notice of Privacy Practices also describes my rights and Healing Hands Chiropractic and Massage duties with respect to my protected health information.

I have the right to revoke this consent in writing, at any time, except to the extent that Healing Hands Chiropractic and Massage or Dr. Melinda S. Benn has taken action in reliance on this consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent / Guardian / Personal Representative if necessary

### Reminder Call Policy

I understand that is it the policy of Healing Hands Chiropractic and Massage to place appointment reminder texts or calls the work day before my appointment. I would appreciate it if the reminder call was placed to the primary number listed on the front of this form.

**If I am not available, I give permission:** For a Message to be left in text or on my voice mail or with anyone who may answer my phone.

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

### Healing Hands Insurance Policy

We will gladly bill your Insurance Company for payment of services rendered. Please inform the front desk if you are aware of any deductible or co-pays. Ultimately your insurance is a contract between you and your insurance company. You will be responsible for payment of any deductibles, co-pays or rejected services.

We are in network with many insurances, including, but not limited to Blue Cross/ Blue Shield, Cigna, United Health Care, Humana and Aetna. The best way to know your coverage is to contact your insurance and ask what your coverage is for Spinal Manipulation provided by a Chiropractor.

We Do Not Participate with or Bill : Blue Care Network (BCN)  
Workman's Comp  
Auto Accident Insurance  
Any Medicaid Program

I have Read and Agree to the Above Information. Signature \_\_\_\_\_ Date \_\_\_\_\_

If you have and questions or problems please discuss them with the front desk.  
We will be happy to assist you in any way we can.