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/or2nd 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.

Past	Current	Condition
5	10	Migraines
3	10	PMS

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

		Pneumonia
		Asthma

Please Take Your Time

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

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. Environmental, Chemical, or Drug Sensitives ? 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

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?_____

_____

What position do you sleep in ? Back_____Right Side_____Left Side_____Stomach_____

How Many Hours Do You sleep each night ?_____

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
Any HMO

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.