Semlow Chiropractic
Wellness Center
Think Well — Eat Well — Move Well

5353 Grand Haven Road, Ste A
Norton Shores, MI 49441
(231) 798-WELL (9355)
Fax (231) 799-1777

Confidential Patient Health Record

Today's Date:____/____/_____

Personal Information

First:_____ Middle:_____ Last:_____ Preferred Name:_____

Address:_____ Apt # _____ Sex: □Male □Female

City:_____ State: ____ Zip: _____ Birth Date: _____/_____/_____ Age:____

Marital Status: □Single □Married □Divorced □Widowed □Separated Social Security Number:_____

Employer:_____ Occupation: _____

Employerôs Address:_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ X _____

Cell Phone: (_____)_____-_____ Best Time & No. to Contact:_____

E-Mail:_____ **Preferred Language**: _____

Preferred method of communication for automatic patient reminders (*Please Check one*): □Email □Text □None

How much Notice would you like before your reminder (*Please Check one*): □4 Hours □1 Day □2 Days □1 Week

For Text Message Reminders Please List Your Cell Provider: _____

CMS requires providers to report both race and ethnicity

Race (Please Check one): □ American Indian or Alaska Native □ Asian □ Black or African American
□ White (Caucasian) □ Native Hawaiian or Pacific Islander □ Other □ I Decline to Answer

Ethnicity (Please Check one): □ Hispanic or Latino □ Not Hispanic or Latino □ I Decline to Answer

Insurance Company:_____Insuredôs Date of Birth**:** _____/_____/_____

Insuredôs Name:_____ Insuredôs Phone: (_____)_____-_____

Spouseôs Name:_____ Spouseôs Date of Birth: _____/_____/_____

Spouseôs Insurance Company:_____Spouseôs Employer:_____

Number of Children:_____ Names, Ages and Gender:_____

_____

_____

Who May We Thank for Referring You to Our Office?_____

Please let us know of the ways that you have heard about us? **(Please Mark all that apply)** □Family □Friend
□Co-Worker □Drove by □Phone Book □Close to home/work □Insurance Plan □Radio □Newspaper □Lecture
□Screening □Web Page □Internet □Google □Yelp □Dr. _____
□Other:_____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____

Address: _____

Relationship: □Spouse □Relative □Friend □Other _____

Please briefly describe your chief concern, including the effect it has had on your life. _____

_____

_____

Health Concerns

Please List health concerns or areas of Pain, According to their Severity.	Rate of severity 1=mild 10=worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are your symptoms Constant, Frequent, Intermittent, or Occasional?
1.					
2.					
3.					
4.					
5.					
6.					

If you are experiencing pain is it: □**Sharp** □**Burning** □**Dull Ache** □**Numbness**
Does the pain travel/radiate anywhere: □**Yes** □**No** if Yes please describe ____

_____

Since the problem started, it is: □**About the same** □**Getting Better** □**Getting Worse**
What makes it worse? _____

_____

Does the problem get worse when it is **Cold** □**Yes** □**No** or **Damp** □**Yes** □**No**
Is the pain worse? □**Morning** □**Afternoon** □**Night** □**With Activity** □**N/A**
What have you done for this condition that has helped you feel better? _____

_____

_____

What have you done for this condition that was no help? _____

_____

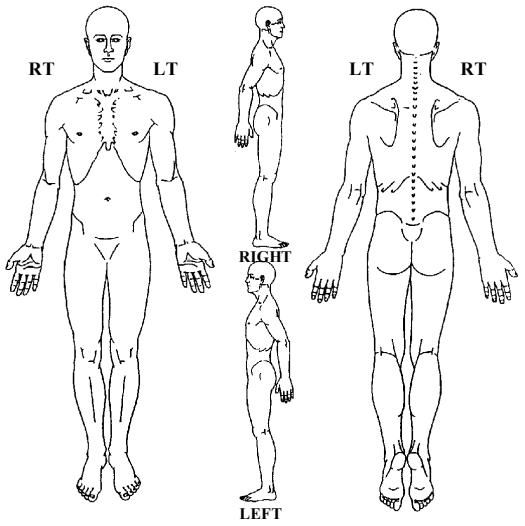
_____

□**I do** □**do not** have a family history of this or similar symptoms (if you do, please explain) _____

_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **S** = STABBING
X = STIFFNESS **T** = THROBBING **P** = PINS & NEEDLES



Is the Condition: □**Auto Related** □**Job Related** □**Home Injury** □**Slip or Fall** □**Lifting** □**Slept Wrong** □**Unknown Cause**
□**Other** Explain: _____

Is this condition interfering with your: □**Work** □**Leisure** □**Sleep** □**Sports/exercise/walking** □**Positive mental attitude**
□**Hobbies** □**Other:** _____

Have you had to, or felt the need to make any ñpositiveò changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) If so what? _____

_____

_____

Other Doctors seen for this condition: □**Chiropractor** □**Medical Dr.** □**Other**

1. Name/Address: _____
   Date: _____ What was the diagnosis? _____
   What was done? _____
2. Name/Address: _____
   Date: _____ What was the diagnosis? _____
   What was done? _____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: **☐ I have not previously seen a Chiropractor / If Yes please fill in the information below.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? ☐Yes ☐No. Why? _____

Current Medication(s): **List ANY/ALL medications you are CURRENTLY taking.** Enter NONE if you are not taking any.
(Please include regularly used over the counter medications) (If you need more room please attach additional sheets)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)	For What Condition?	How long have you been taking this?

Do you have any medication allergies? Please enter NONE if you do not have any medication allergies.
(If more room is needed please attach additional sheets)

Medication Name	Reaction	Onset Date	Additional Comments

Current Vitamins, Herbs, etc: **List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**
Please enter NONE if you are not taking any Supplements. (If more room is needed please attach additional sheets)

Current Vitamins, Herbs, non-prescription, *etc*	Dosage and Frequency (i.e. 5mg once a day, etc.)	For What Condition?	How long have you been taking this?

Smoking Status (*Please Check one*): ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

Have you had any surgery? (Please include all surgery) (If you need more room please attach additional sheets)

1. Type _____ Date _____ Doctor _____
2. Type _____ Date _____ Doctor _____
3. Type _____ Date _____ Doctor _____
4. Type _____ Date _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type _____ Date _____ Hospitalized ☐Yes ☐No
2. Type _____ Date _____ Hospitalized ☐Yes ☐No
3. Type _____ Date _____ Hospitalized ☐Yes ☐No
4. Type _____ Date _____ Hospitalized ☐Yes ☐No

Have you ever had x-rays taken? (if yes) When _____ Where _____

Area of body: _____

Do you wear any of the following? ☐Heel Lifts ☐Innersoles ☐Arch Supports ☐Orthotics ☐ Other _____

General History:

REVIEW OF SYSTEMS- REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment**.** However, these questions must be answered carefully as the problems can affect your overall course of care.

In the following sections please check all boxes **that apply in the past 12 Months**
(If none apply please check **DENY ALL** on the **bottom of that Section**.)

Constitutional:

☐ chills ☐ daytime drowsiness ☐ fatigue ☐ fever ☐ night sweats
☐ weight gain ☐ weight loss ☐ other: _____
☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Ears, Nose and Throat:

☐ bleeding ☐ dentures ☐ difficulty swallowing ☐ discharge ☐ dizziness
☐ ear drainage ☐ ear pain ☐ fainting ☐ frequent sore throats ☐ headaches
☐ hearing loss ☐ history of head injury ☐ hoarseness ☐ loss of sense of smell ☐ nasal congestion
☐ nosebleeds ☐ postnasal drip ☐ rhinorrhea (runny nose) ☐ sinus infections ☐ snoring
☐ sore throat ☐ tinnitus (ringing in ears) ☐ TMJ problems ☐ other: _____
☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Respiration:

☐ asthma ☐ cough ☐ coughing up blood ☐ shortness of breath ☐ sputum production
☐ wheezing ☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Cardiovascular:

☐ angina (chest pain or discomfort) ☐ chest pain ☐ claudication (leg pain/ache)
☐ heart murmur ☐ heart problems ☐ high blood pressure
☐ low blood pressure ☐ orthopnea (difficulty breathing lying down) ☐ palpitations
☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) ☐ shortness of breath with exertion or exercise ☐ swelling of legs
☐ ulcers ☐ varicose veins ☐ other: _____
☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Gastrointestinal:

☐ abdominal pain ☐ belching ☐ black - tarry stools ☐ constipation ☐ diarrhea
☐ difficulty swallowing ☐ heartburn ☐ hemorrhoids ☐ indigestion ☐ jaundice
☐ nausea ☐ rectal bleeding ☐ abnormal stool caliber ☐ abnormal stool color ☐ abnormal stool consistency
☐ vomiting ☐ vomiting blood ☐ other: _____
☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Female:

☐ birth control ☐ breast lumps/pain ☐ burning urination ☐ cramps ☐ frequent urination
☐ hormone therapy ☐ irregular menstruation ☐ pregnancy ☐ urine retention ☐ vaginal bleeding
☐ vaginal discharge ☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Male:

☐ burning urination ☐ erectile dysfunction ☐ frequent urination ☐ hesitancy/dribbling ☐ prostate problems
☐ urine retention ☐ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Endocrine:

□ cold intolerance □ diabetes □ excessive appetite □ excessive hunger □ excessive thirst
□ abnormal frequency of urination □ goiter □ hair loss □ heat intolerance □ unusual hair growth
□ voice changes □ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Skin:

□ changes in nail texture □ changes in skin color □ hair growth □ hair loss □ hives
□ history of skin disorders □ itching □ paresthesias □ rash □ skin lesions / ulcers
□ varicosities □ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Nervous System:

□ dizziness □ facial weakness □ headache □ limb weakness □ loss of consciousness
□ loss of memory □ numbness □ seizures □ sleep disturbance □ slurred speech
□ stress □ strokes □ tremor □ unsteadiness of gait □ loss of balance
□ other: _____
□ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Psychologic:

□ anhedonia □ anxiety □ loss or change in appetite □ behavioral change □ bi-polar disorder
□ confusion □ convulsions □ depression □ insomnia □ memory loss
□ mood change □ other: _____
□ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Allergy:

□ anaphalaxis □ food intolerance □ itching □ nasal congestion □ rash
□ sneezing □ other: _____
□ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Hematologic:

□ anemia □ bleeding □ blood clotting □ blood transfusion □ bruising easily
□ fatigue □ lymph node swelling □ other: _____
□ **I DENY having or have had any of the symptoms or problems listed in this Category.**

Females ONLY: **Mark all that apply below.**

I AM: □ **currently pregnant** □ **NOT pregnant** □ **unsure**
Past Pregnancy History: □ **C-section** □ **vaginal delivery** □ **miscarriage**

Do you have a Primary Health Care Provider? □**Yes** □**No** if Yes please list their Name: _____
Your Dr's Address (if Known): _____
Your Dr's Phone Number (if Known): _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Because the health of your family can affect you physically and emotionally, please list below their names and any health conditions or concerns they may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

_____

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   - **a.** _____
   - **b.** _____
   - **c.** _____

2. Bio-Chemical stress (smoke, unhealthy foods, missed meals, donôt drink enough water, drugs, etc.).
   - **a.** _____
   - **b.** _____
   - **c.** _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)
   - **a.** _____
   - **b.** _____
   - **c.** _____

Pop/Soda: #_____cans per □ Day □ Week; **Coffee**: #_____cups per □ Day □ Week;

How many ounces of **water** a day do you drink _____

On a scale of 1-10 describe your **psychological/emotional stress** levels(1= none/10=extreme)

Occupational:_____ Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating Habits: _____ Exercise Habits: _____ Sleep: _____ General Health: _____ Mind Set: _____

If there is a need for dietary changes or nutrients would you like to be informed? □**Yes** □**No**

If there is a need for specific exercises would you like to be informed? □**Yes** □**No**

If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed? □**Yes** □**No**

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. The success of the chiropractic doctorôs procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as ñinformed consentò and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Print Name: _____

Patient's or Guardian's Signature Authorizing Care: _____ Date: _____

Guardian's Signature to treat a Minor and Authorizing Care: _____ Date: _____

MASSAGE POLICY

Our office policy requires 24-hours notice if you are not able to keep your massage appointment. This policy enables us to insure availability for all of our patients. As a courtesy, reminder phone calls are made for massages. However, if you do not receive a call, you are still responsible for your scheduled appointment. Failure to make your appointment will result in charges to your account. Being fifteen minutes or more late will result in charging your account the difference between your scheduled massage and the actual time received. We do not bill insurance for late or missed massages.

If we are billing your insurance for massages you must be a current chiropractic patient of Semlow Chiropractic. Insurance companies only pay for massages if they are considered a medical necessity. Insurance companies do not pay for massages for leisure reasons.

Although, we love having children in the office and encourage you to bring them with you during your adjustment, we are unable to watch your children during massages. Please make other arrangements for your children during massage time.

We appreciate your cooperation so that we can insure that all of our patients will have equal time and availability with our massage therapists.

Patient's or Guardian's Signature: _____ Date: _____

APPOINTMENT POLICY

1. If you are unable to keep an appointment for any reason, we request that you provide us with at least 24 hours notice. Emergencies are an exception.
2. Please call ahead if you have experienced any **CHANGE OF CONDITION,** (such as falls, surgeries or accidents). This ensures you more time with the doctor to discuss your condition.

FINANCIAL POLICY

1. Our fees for service are the same for all patients whether or not they are covered by insurance.
2. In the event that you discontinue care prior to the Doctorôs consent, you are responsible to pay in full any and all outstanding balances within 10 days. Insurance assignment patients are required to pay any and all outstanding claims in full.
3. Zero Balance Policy. According to our policy all co-pays and deductibles are due before the time of service. Statements will be mailed to patients with balances over $10. Any unpaid balance over 60 days will incur a $3 charge per month; this fee does not apply to patients that have a written payment plan (described below in #4) with the office.
4. We have several payment plan options in the office. You may prepay for your care or pay per week or month. All payment plans must be in writing and on file in the office to be effective. As part of your payment plan, you may leave a credit card on file and authorize a specific payment or the balance in full be charged on the 1st and/or 15th of each month. You may also have your payment direct debited from your checking or savings account for no additional fee on the 1st or 15th of each month.
5. All returned checks are subject to a $30 charge.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negative will remain the property of this office, remaining on file where they may be seen at any time while I am a patient of this office.

As a courtesy to our patients, we call to verify insurance coverage. This is not, however a guarantee of benefits; only after your claim has been submitted and we receive your Explanation of Benefits can we tell you exactly what your insurance coverage is. Any portion of your balance not covered by your insurance will be your responsibility.

Your signature below indicates you understand and agree to the policies set forth above.

Patient's or Guardian's Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Michigan.

I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

This Authorization for Assignment will be in continual effect until revoked by both parties.

Patient's or Guardian's Signature: _____ Date: _____

CLINICAL SUMMARIES (Please Check One)

I would like the ability to receive clinical summaries either through e-mail or web access.

I choose to decline receipt of my clinical summary after every visit.

Patient's or Guardian's Signature: _____ Date: _____

Semlow Chiropractic
Wellness Center
Think Well — Eat Well — Move Well

5353 Grand Haven Road, Ste A
Norton Shores, MI 49441
(231) 798-WELL (9355)
Fax (231) 799-1777

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____