COMMUNITY FIRST CHIROPRACTIC

107 Lewis Street

Gibsonville, NC 27249

haleighcooperdc@gmail.com

Participant Health Profile Welcome to Community Chiropractic! Please fill out everything on this form, even if you feel it does not apply to the reason you are coming in for care. Thank you for choosing us as part of your healthcare team.

Who referred you to our office? _____ May we thank them? Yes No

General Information:

Name: _____ What do you like to be called?_____.

Gender: M / F / Other_____ Date of Birth: ___/___/____ Age: ____ Height: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Emergency contact:

Name_____ Phone: _____ Relation:_____

(Rate your family's health by writing a number by their name below using the scale: 0 = poor health ⚜ 10 = excellent health)

Married/Life Partner? Yes___ No___ Significant Other's Name: _____

Children's Name(s) and Age(s): _____

Occupation: _____ Employer: _____

Do you enjoy what you do? Y / N Explain: _____

Duties/ Habits: ___ sit more than 1 hour ___ carry equipment/tools on your body (i.e. utility belt, child)___ repetitively bend or twist ___ cradle the phone shoulder to ear (which side? L or R) ___ repetitively type ___ drive on the job (car or other) ___ lift more than 10 lbs repetitively

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About Your Health

The human body is designed to be healthy. Throughout life events occur and our body has two options: It can either integrate experiences or store them to be integrated at a later time when the body is better capable. These stored experiences eventually become symptoms in the body, thus giving us a lesser quality of life. This case history will uncover the layers of stored experiences in your body. Following the exam, you will get an outline of care that will begin to correct and release these layers and recover your innate health potential.

Provider's Name Provider Type Last Visit Reason Result

_____

_____

_____

Current Health Concerns (Please follow instructions carefully. We will cover all health concerns verbally.)

List your top three health concerns: _____

_____

Which is most important to you and why? _____
When/how did this concern first begin? _____
What activities aggravate your concern? _____
What activities alleviate your concern? _____
Is the condition worse during certain times of the day? Y N If yes, when? _____

Does it affect your ___work ___relationships or intimacy ___decision making ___exercise or play

___attitude, mood, patience ___ability to relax or sleep ___ day-to-day activities

Do you have ___pain ___numbness ___tingling ___aches

Is your pain ___sharp ___dull ___throbbing ___constant ___intermittent

Do you feel ___swelling ___cramping ___stiffness ___burning

Do you have any other health concerns? _____

Your Mom's Pregnancy with You/ Your Birth: (check all that apply)

___Tobacco	___Alcohol	___Medications	___ Recreational drugs
___Falls/injuries	___Abuse (any type)	___ Hospital	___Home
___Vaginal	___Cesarean	___Vacuum	___Forceps
____Medications	___Epidural	___Complications	

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Childhood (Age 0-18): (check all that apply)

___Breast fed ___Formula fed (Dairy or soy?) ___Abuse (any type) ___Surgeries

___Accidents/falls/injuries ___Dislocations/fractures ___Scoliosis

___Orthodontics (braces, etc.) ___Nightmares/night terrors ___Played in a hanging/ bouncy swing

___Crawled before walking ___Special diet ___Vaccinations ___Medications

___Allergies/Eczema ___Asthma ___Ear infections

Current Health/Stress

Diet: (Unhealthy = 0 ◎ Extremely Healthy = 10) Your score? ___ Details: _____

Special Diet? ___Gluten free ___Paleo ___Vegetarian ___Vegan Other:_____

Food sensitivities: _____ Food Allergies:_____
Vitamins or supplements: type, what for, and who recommended? _____

_____

Medications: type and for what? _____

Exercise: Frequency/ type:_____

Water (Type and amount per day): _____

How much do you consume per day of the following?

Caffeinated coffee: _____ Decaf coffee:_____ with cream? Y N With sugar? Y N
Caffeinated tea: _____ Decaf tea:_____ with cream? Y N With sugar? Y N
Caffeinated soda: _____ Decaf soda:_____ Regular or diet? (circle one)

Energy drinks: _____ Juice:_____ Type:_____
Tobacco: _____ Alcohol: _____ Type:_____

Rate your stress level for each on a scale of: 0 = worst ◎ 10 = best (i.e. If you love your job & it's stress-free put a "10")

___Occupational stress ___Mental/emotional stress ___Physical stress ___Chemical stress

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Adult History (Age 19 to present): Mark all that apply with (N) for Now, (P) for Past

___ Weight Changes	___ Frequent Colds/Flu	___Asthma/Respiratory Disease
___Sinus/Allergies	___Skin Conditions	___Anemia
___Neck/Back pain	___Numbness/Tingling	___Arthritis (Type: _____)
___High Cholesterol	___Stroke	___High Blood Pressure
___Concussion/Head Injury	___Digestive Issues	___Urinary Tract Issues
___Bowel/Bladder Issues	___Menstrual Issues/Pain	___Reproductive System Disorders
___Menopause	___Thyroid Disorder	___Prostate Issues
___Ears/Hearing Issues	___Eyes/Vision Issues	___Dental/Jaw Issues
___Cancer	___Depression	___OCD
___Bipolar Disorder	___Autism Spectrum Disorder	___Pregnancies
___Surgeries	___Injuries/Accidents	___Dislocations/Fractures
___Abuse (Any type)	___Tobacco	___Alcohol
___Recreational Drugs	___Vaccinations	___Chronic Fatigue

Chiropractic History

Have you been to a chiropractor before? Yes No

How old were you the first time you were adjusted? _____

Who was your most recent chiropractor? _____

When was your last adjustment? _____ Reason for visit: _____

Result: _____

Describe techniques used: _____

In your own words, what do chiropractors do? _____

_____

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What do you wish to get from receiving chiropractic care? _____.

_____.

Is there anything else that may help us to understand you, your history, or your needs which has not been discussed on this survey? _____

_____

*** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in this process.

Signature: _____ Date: _____

Chiropractor Name: _____ Date: _____

Chiropractor Signature: _____

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FEMALS ONLY

History on Past and Current Pregnancies and Births

(Include if you have ever been pregnant)

Are you currently pregnant? Yes / No

How many weeks are you? _____ Guess Date: _____

Do you plan on birthing at: ___Home ___Birthing Center ___Hospital

If not birthing at home, please name birthing location: _____

Do you plan on using a: (check all that apply) ___Doula ___Midwife ___Nurse Midwife ___OB
Names:_____

Do you plan on breastfeeding? (Please answer assuming there are no unexpected issues.)

Yes: For how long and why?_____

No: Why not? _____

Do you plan on vaccinating this child? Yes No

If yes, what type of schedule are you choosing: ___CDC Full ___Delayed Full ___Modified

Why? _____

Have you done your own research on vaccinations? _____

Have you ever had an abortion? Yes No Complications? _____

Have you ever had a miscarriage? Yes No Complications? _____

Past Deliveries: How many? _____

*Please answer the following questions regarding your most recent birth.

Third Trimester Presentation: ___Vertex (head down) ___Breech ___Transverse ___Face/Brow

___Posterior Type of Birth: ___Vaginal ___Forceps ___Vacuum ___Cesarean (ER or planned?)

Interventions: ___Medication ___Epidural ___Ruptured Membranes ___Episiotomy ___Assisted Pushing

Delivery Location: _____

OB/Midwife Name: _____

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, subtle energy rebalancing and supportive therapies on me (or on the person named below for whom I am legally responsible) by Haleigh Cooper, DC at Community First Chiropractic .

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, sprains, fractures, disc injury, stroke and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions and ultimately improve health. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands upon my body to adjust joints and release muscles, which may cause an audible “click” or “pop” during the procedure.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for adjustment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and can secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, 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 communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

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

_____ _____

Name (Printed) Date Signed

_____ _____

Signature: Patient or Legal Representative Guardian, Parent) Witness to Patient’s Signature

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Terms of Acceptance / Philosophical Agreement

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

- There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
- The Nerve System is the main coordinating and distribution system for the body's innate intelligence.
- Alterations or distortion in the shape, position, tone, or tension of the Nerve System (especially at the spine) will interfere with the expression of this intelligence.
- Chiropractors call this interference to the proper functioning of the Nerve System a Vertebral Subluxation. Subluxation causes alternation in nerve function and distorts the communication channels between the brain and the body. The result is a lessoning of the body's ability to express its maximum health potential.
- Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.
- An Adjustment is the specific and honoring application of forces to facilitate the body's release and integration of subluxation.
- The sole purpose of the chiropractic adjustment in this office is to assist your body to release vertebral subluxation and benefit from the restoration of clear communication channels in the body. Everyone, regardless of their age, symptoms or ailments, will benefit from a nerve system which is more flexible, elastic, and free of vertebral subluxation.
- Chiropractic is not a substitute, an alternative or a preventative form of medicine. We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body's innate wisdom and to support your body to hold and integrate adjustments and healing. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.

I, _____, have read the above statements and understand the doctor's objectives pertaining to my care in this office. I accept chiropractic care on this basis.

Signature Date

Consent to evaluate and adjust a minor/child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms and acceptance and hereby grant permission for my child to receive chiropractic care in this office.

Signature

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Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Community First Chiropractic's (CFC) Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for CFC to provide treatment to me, and necessary for CFC to obtain payment for that treatment and to carry out its health care operations. CFC explained to me that the Privacy Notice will be available to me in the future at my request. CFC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.
2. CFC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law and I will be informed of any revisions.
3. I understand that, and consent to, the following communications that will be used by CFC: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me. [Please note: email and text messages are not secure, protected forms of communication. By signing below you are acknowledging your choice to use them to communicate PHI.]
4. CFC may use and/or disclose my PHI in order for CFC to treat me and obtain payment for that treatment, and as necessary for CFC to conduct its specific health care operations.
5. I understand that I have a right to request that CFC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, CFC is not required to agree to any restrictions that I have requested. If CFC agrees to requested restrictions, then the restriction is binding on CFC.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the CFC has already taken action in the reliance on this consent.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, CFC will not treat me. I further understand that if I revoke this consent, at any time, CFC has the right to refuse to treat me.
8. CFC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in CFC's practice.
9. Visits and spinal adjustments are performed in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. If you have comments or information you wish to share privately when you come into the adjustment room please inform the doctor or staff and we will accommodate your needs.

I acknowledge that I have received a copy of CFC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer, Haleigh Cooper. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____ _____

Patients 's Name (printed) Date Signed

_____

Signature (patient or legal representative)

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RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Community First Chiropractic. The written notice must contain the following information: your name and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Community First Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Community First Chiropractic will not refuse to provide treatment however, it will not be possible for Community Chiropractic to contact me to schedule appointments or discuss my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.