STEADFAST CHIROPRACTIC

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Phone: Cell_____ Home_____

Email Address: _____

When you provide us with your contact information, we may use that information to provide you services. For example, we may use your contact information to send you appointment reminders and office updates via text or SMS message, along with sending you exercises through your email. We may use business partners to provide these services to you. If you do not wish for us to share that information with any third parties, please notify us. But recognize that if you choose not to share the information, we may not be able to provide you with certain services.

Have you ever served in the Armed Forces/Military? _____

Occupation_____ Employer's Name_____

Status: Single / Married / Divorced / Widowed Spouse's Name_____

Kids Name/Ages_____

Who may we thank for referring you to our office?_____

HISTORY of COMPLAINT

Health Concern(s): (List according to severity)	**Rate of Severity** 1 = mild 10 = unbearable	**When did this problem start?**	**Did you have this condition before & when?**	**Did the problem begin with an injury?**	**Are symptoms constant (C) or intermittent (I)?**
1._____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

Please mark **P** for in the **Past** OR mark **C** for **Currently** have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

___Cancer ___Heart Attack ___Diabetes ____Spinal Surgery ___Spinal Fracture

___Stroke ___Seizure ___Pregnant?/Due Date:_____ Other:_____

Please list any medications or supplements you are taking:_____

_____

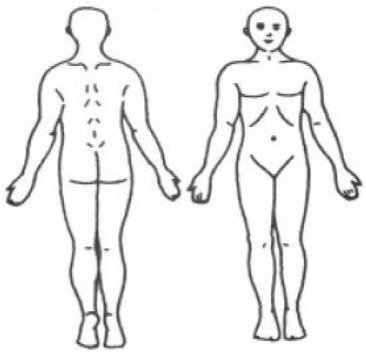
Steadfast Chiropractic, PLLC

A: 974 E. Michigan Ave Saline, MI 48176 P:734.999.0165 E: info@getsteadfast.com

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching

N = Numbness **S** = Sharp/Stabbing **T** = Tingling



Social History

1. **Smoking:** How often? □ Daily □ Weekends □ Occasionally □ Never
2. **Alcohol:** How often? □ Daily □ Weekends □ Occasionally □ Never
3. **Exercise:** How often? □ Daily □ Weekends □ Occasionally □ Never
4. **Recreational Drug Use:** How often? □ Daily □ Weekends □ Occasionally □ Never

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Back pain Headaches Worst possible pain

0 1 2 3 4 5 (6) 7 8 (9) 10

1. How would you rate your pain **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Andrew Schneider, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child:

_____

I authorize Dr. Andrew Schneider and any and all Steadfast Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Steadfast Chiropractic.

Guardian Signature: _____ Date:_____

Relationship To Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Please provide a list of anyone you give us permission to speak to about your Health, Financials or both:

Please circle one of the following:

Name: _____ Relationship to you: _____ Health Financials Both

Name: _____ Relationship to you: _____ Health Financials Both

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Steadfast Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Steadfast Chiropractic.

Signature: _____ Date: _____

Media Release Form

If I choose to give a testimonial, for valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Steadfast Chiropractic, PLLC or anyone authorized by Steadfast Chiropractic, PLLC of any and all photographs/videos which were taken, for the purpose of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute as property of Steadfast Chiropractic, PLLC solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regard to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Steadfast Chiropractic, PLLC to share this information via their website and their Facebook/social media including Twitter, Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws)

Initial: _____