Welcome to

Anchor Chiropractic

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask us. All of your questions, even the ones you haven't thought of yet, will be answered during your Chiropractic Report.

Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

Personal and Family Health History

Name _____ Referred By _____
Date _____ Occupation _____
Address _____ Employer _____
City _____ State ____ Zip _____ Marital Status S M D W
Phone: (H) _____ (C/W)_____ Spouse's Name _____DOB_____
E-mail _____ Spouse's Occupation _____
Date of Birth _____ (Age _____)

Number of Children and Ages ***Previous Chiropractic Care?***

Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____

You deserve to be healthy. When you were conceived, you were given the blueprints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply	***Patient***	***Spouse***	***Child#1***	***Child#2***	***Child #3***	***Chiropractor's Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____

Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture (side–stomach–back)	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
Major _____
Pain or Problem started on_____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you been under drug and medical care? _____
What medications are you taking? _____
How Long? _____ Have you had surgery? _____ What? _____ When?_____
What side effects have you experienced from the drugs and surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.

❒ Still living ❒ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❒ Feel better quickly ❒ Have a healthier spine and nervous system ❒ Live a healthier lifestyle

_____ _____
Signature Date

Anchor Chiropractic - a 100 Year Lifestyle Affiliate Office

Office Fee Schedule and Financial Policy

Service	Fee
Meet the Doctor Visit	$ Complimentary
Initial History and Examination	$ 82 - 310 (most are $165)
X-Rays	$ 220 (full spine survey)
ReExams	$ 85
Adjustment	
spinal	$ 70 - 93 (most are $78)
extremity(s) [eg. wrist, ankle, knee]	$ 37

extra

Financial Policy and 100 Year Lifestyle Plans

Our office attracts generations of people looking to live active, healthy, long lives, enjoying the activities they love every day along the way. Our 100 Year Life Plans give people the freedom and strategy to attain the health goals and potential they want and desire. Unfortunately, we have found through years of experience that insurance companies (with their limitations, restrictions, and sick care philosophy) actually become a barrier to this happening. As such, to ultimately empower our patients to steer their own health care decisions and lifestyles, **we are not contracted with insurance companies.** (For more information, please inquire at the front desk). The 100 Year Lifestyle Plans are the greatest value for receiving this type of care in our office — enabling you to get the care that you want with the greatest cost and time savings.

- Payment is expected as services are rendered unless prior financial arrangement have been made.
- Discounts on the above fees are offered through our 100 Year Lifestyle Plans.
- Additional discounts may be extended to Individuals/Families if the requirements for our financial assistance program are met. If you are interested, please ask for a hardship application.

I, _____ have read and I understand the above
name

_____

signature date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
signature date

ANCHOR CHIROPRACTIC

PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree to the following:

1. I understand that this Patient Consent is a summary of the Anchor Chiropractic's 5-page Privacy Notice which is available for my review by inquiring at the front desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Anchor Chiropractic (hereinafter referred to as "the Practice") to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice 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 this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand, and consent to, appointment reminders which may be utilized by the Practice. Appointment reminders may include, but are not limited to: automated texting and/or voice calls, standard telephone calls, postcards, voice mail messages or messages with the individual answering the telephone.

4. I understand, and consent to, the Practice having the option of recognizing me by listing my name in the Practice newsletter (electronic or print) should I refer a patient to the office.

5. I understand, and consent to, that if I have been referred to the Practice by another patient, that patient may receive a "Thank you," whether verbally or by letter (electronic or print) which will reference my name.

6. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

7. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

8. 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 that the Practice has already taken action in reliance on this consent.

9. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

10. 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, then the Practice has the right to refuse to treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Relationship

Date Signed _____/_____/_____

Witness:_____