**Participant Health Profile**

*Welcome to Hands On Wellness! 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.*

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**Please check the type of care desired:**

\_\_\_ Temporary Relief \_\_\_ Stabilization \_\_\_ Family Health/ Prevention \_\_\_Doctor’s Advice

**Is this appointment related to an**:

\_\_\_ auto accident \_\_\_ injury on the job? *(If yes, please speak with front desk before continuing)*

**Who referred you to our office?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: Male / Female

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_/\_\_\_/\_\_\_ **Age**: \_\_\_\_ **Weight**: \_\_\_\_\_ **Height**: \_\_\_\_\_

**Married/Life Partner?** Yes\_\_\_ No\_\_\_ **Significant Other’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children(’s) Name(s) and Age(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact**: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you enjoy what you do**? Y N **Can we contact you there if needed?** Y N

**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

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently on a work release**? Y N **Ordered by whom and why?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**About Your Health**

*The human body is designed to be healthy. Throughout life events occur and our body has two choices: 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 Chiropractic Exam, you will get an outline of care that will begin to correct and release these layers and recover your innate health potential!*

**Your Healthcare Team** (include all doctors, therapists, trainers, specialists, etc)

**Provider’s Name Provider Type Last Visit Reason Result**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Health Concerns**

What is the **primary reason** for your appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**When/how** did this concern first begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities **aggravate** your concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What activities **alleviate** your concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is the condition worse during certain times of the day? Y N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it affectyour \_\_\_work / \_\_\_relationships or intimacy / \_\_\_decision making / \_\_\_exercise or play

 \_\_\_attitude, mood, patience / \_\_\_ability to relax or sleep / \_\_\_ day-to-day activities

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On a scale of 1-10 (1 least, 10 most), please circle the severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Do you have \_\_\_pain \_\_\_numbness \_\_\_tingling \_\_\_aches Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain \_\_\_sharp \_\_\_dull \_\_\_throbbing \_\_\_constant \_\_\_intermittent Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel \_\_\_swelling \_\_\_cramping \_\_\_stiffness \_\_\_burning Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

Your **Mom’s Pregnancy** with You: (check all that apply)

\_\_\_Tobacco \_\_\_Alcohol \_\_\_Medications \_\_\_ Recreational drugs \_\_\_Falls/injuries \_\_\_Abuse (any type)

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Birth**: (check all that apply)

\_\_\_ Hospital \_\_\_Home \_\_\_Vaginal \_\_\_Cesarean (Emergency or scheduled?) \_\_\_Vacuum \_\_\_Forceps

\_\_\_Medications \_\_\_Epidural \_\_\_Complications Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_Breast fed \_\_\_Formula fed (Dairy or soy?) \_\_\_Abuse (Physical, sexual, or emotional?) \_\_\_Surgeries

\_\_\_Accidents/falls/injuries \_\_\_Dislocations/fractures \_\_\_Scoliosis \_\_\_Orthodontics (braces, retainer, etc.)

\_\_\_Nightmares/night terrors \_\_\_Played in a hanging/ bouncy swing \_\_\_Crawled before walking

\_\_\_Special diet \_\_\_Vaccinations \_\_\_Medications \_\_\_Allergies/Eczema \_\_\_Asthma \_\_\_Ear infections

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Adult History** (Age 18 to present)

**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_ Weight changes \_\_\_ Frequent Colds/Flu \_\_\_ Asthma/Respiratory disease \_\_\_ Sinus problems/Allergies

\_\_\_ Anemia \_\_\_ Skin Conditions \_\_\_ Neck/Back pain \_\_\_ High cholesterol

\_\_\_ Stroke \_\_\_ High blood pressure \_\_\_ Depression \_\_\_ Bipolar disorder

\_\_\_ OCD \_\_\_ AD/HD \_\_\_ SAD \_\_\_ Concussion/Head injury

\_\_\_ Digestive problems \_\_\_ Cancer \_\_\_ Menstrual problems/ pain \_\_\_ Numbness/Tingling

\_\_\_ Dental/Jaw issues \_\_\_ Headaches \_\_\_ Diabetes (Type:\_\_\_\_\_\_) \_\_\_ Urinary Tract Infections

\_\_\_ Arthritis (Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_ Bowel/bladder changes \_\_\_ Dizziness/Vertigo

\_\_\_ Ear/Hearing Issues \_\_\_ Eye/Vision Issues \_\_\_ Reproductive Organ Disorders \_\_\_ Thyroid Disorder

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_Tobacco \_\_\_Alcohol \_\_\_Medications \_\_\_Recreational drugs \_\_\_Vaccinations \_\_\_Falls/injuries \_\_\_Accidents \_\_\_Surgeries/organs removed \_\_\_Dislocations/fractures \_\_\_Sports injuries \_\_\_Abuse (Physical, sexual, emotional?)

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Mark all that apply with (N) for Now, (P) for Past**

\_\_\_Particular diet (type:\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_ Vitamins or supplements (details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_Regular exercise (frequency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_Occupational stress \_\_\_Mental/emotional stress \_\_\_Physical stress \_\_\_Chemical stress

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Sleep habits**: \_\_\_\_ Hours per night / \_\_\_\_Sound or \_\_\_\_Disrupted? / \_\_\_\_ Nightmares / \_\_\_\_ Sleep apnea / \_\_\_\_ Snoring

 Age of mattress \_\_\_\_ yrs / Type of mattress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age of pillows \_\_\_\_\_ yrs / Type of pillows \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Locations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For Females Only:** Please fill out the following questions regarding your own pregnancies/births.

Have you had any abortions or miscarriages? Yes No Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Deliveries:** (Check regarding most recent delivery; include stories on all deliveries.) How many? \_\_\_\_\_\_

Third Trimester Presentation: \_\_\_Vertex \_\_\_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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy/Birth Stories:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current Pregnancy:** 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**? Yes No

 For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Chiropractic History**

Have you been to a chiropractor before? Yes No

How old were you the 1st time you were adjusted? \_\_\_\_\_\_\_

Who was your most recent chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last adjustment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total duration of care at that office: \_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technique used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In your own words, what do chiropractors do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do any of your family or friends receive chiropractic care? Yes No

If yes, do **they** use chiropractic for \_\_\_ health maintenance/optimization

\_\_\_ health problems \_\_\_ both

Are **you** seeking chiropractic care for \_\_\_ health maintenance/optimization

\_\_\_ health problems \_\_\_ both

Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel **impair** your opportunity for full, unimpeded health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or **adds to your health**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there **anything else** which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\* 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Consent Form**

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

***Chiropractic*** is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

***Health*** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

***Subluxation*** is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body’s overall healthy performance.

Subluxations are corrected and/or reduced by an ***adjustment***. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature

\_\_\_\_\_\_\_\_\_\_

Date

**~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~**

**Consent to evaluate a minor child:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature Date

**HEALTHCARE AUTHORIZATION FORM**

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Hands on Wellness Chiropractic to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS:

\_\_\_\_\_\_ I give permission to Hands on Wellness to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

\_\_\_\_\_\_ If Hands on Wellness contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

\_\_\_\_\_\_ I give permission to Hands on Wellness to use my name on a welcome board, referral board, and birthday board.

\_\_\_\_\_ I give permission to Hands on Wellness to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

\_\_\_\_\_ I give permission to Hands on Wellness to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

\_\_\_\_\_\_ I give Hands on Wellness permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Hands on Wellness permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Hands on Wellness plus 7 years or until revoked by me.

**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 Hands on Wellness 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 Hands on Wellness 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, Hands on Wellness Chiropractic will not refuse to provide treatment however, it will not be possible for Hands on Wellness 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.

**HEALTHCARE AUTHORIZATION**

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Personal Representative (if someone is designated to act on your behalf/or for minor)

Parent or Personal Representative’s name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_