elevation
HEALTH
Live your life

Thank you for choosing Elevation Health as part of your health care needs today! We look forward to helping you achieve the health you were made to enjoy. During your visit at our office you will meet the friendliest people on the planet! Our amazing staff is there to help you with whatever it is that you need. When you come in we will briefly go through your paperwork with you to make sure everything is complete. Then they will take you on a tour of the office and show you what makes our office different and unique from all other Chiropractors offices, explaining why we have dependable, predictable and reproducible results that provides an astounding 95% success rate restoring function, eliminating and preventing common diseases, and regaining a healthy life.

This packet is your first step towards your exciting new future. Your appointment time is the actual time you will be expected to see your doctor. *Please arrive 15 minutes prior to your scheduled appointment time* so that our staff can go over this packet with you. Please bring your driver's license or identification card and insurance card, if you have one.

IT IS VERY IMPORTANT TO FILL OUT ALL OF THE PAPERWORK AS COMPLETELY AS POSSIBLE BEFORE YOU ARRIVE. Do not leave anything blank; it will save you at least 30-45 minutes of your time at our office. If you need assistance filling your paperwork, please arrive 30-45 minutes prior to your appointment time and our staff will be happy to assist you.

After your tour you will meet with your doctor who is going to start the exam and consultation which includes a comprehensive orthopedic examination, a complete postural assessment, as well as a detailed neurological assessment. The doctor will also test motion and static palpation which means that he is going be feeling your spine with his or her hands so they can see exactly where your imbalance is. At that point if the doctor feels there is any other assessing required to understand your condition they will let you know what testing is needed and what the cost for those tests will be. This will likely be the most complete consultation and exam you have ever been through and will provide the crucial information that will tell us exactly what the cause of your problem may be, how long it has been there and exactly what is needed to restore your health.

Following your initial exam, you will be scheduled for a follow-up visit to help you understand what we have found and whether we can help you. During your follow-up visit, if we have found we can help you, you will have the opportunity to be adjusted. **The money paid today covers the consultation, examination, neurological tests, orthopedic tests, bio-structural posture ($150 value). This fee does not include and necessary x-rays. Any offer and/or discounts do NOT apply to Medicare.**

Due to the high demand for these appointments at this price, if for some reason you need to reschedule your appointment, you will be allowed to reschedule **ONLY** one time.

Thank you for taking the next step to a lifetime of wellness through Elevation Health. We look forward to seeing you and your family at the office!

Elevation Health Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using **black or blue ink**. If there is something that does not apply to you please put **N/A** on the line.)

Section 1: Patient Information

Appt. Date: _____ Referred *By:* _____

Name (first, middle, last):_____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ___/__/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employer: _____ Occupation: _____ Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children: _____

Emergency Contact: _____ Relationship_____ Phone # (____) _____

Section 2: History of Complaint

Primary Complaint(s): _____

Secondary Complaint(s): _____

Are your complaints due to an Accident? ☐ YES ☐ NO If yes, what type? ☐Work ☐Auto ☐ Personal

Date of Accident_____ If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No

Who was it reported To? _____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

_____

List any medications you currently take. (Prescription and non-prescription)_____

_____

_____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ❑ No ❑ Yes

If yes whom & what condition(s): _____

_____

Section 4: Chiropractic History

Have you ever seen a Chiropractor before? ☐ Yes ☐ No When _____/_____/_____

For what reason were you seen? _____ Were you helped? ☐ YES ☐ NO

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ DOB: _____

Section 5: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause **Postural Distortions** (misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't *feel* injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end** **10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/___/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐Lt ☐Rt

Date:___/___/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries:_____ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: 1-1-2008 ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/___/_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/___/_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice & bruised Left Elbow**

Date:___/___/_____ Type of Injury:_____ ☐ Lt☐Rt

Date:___/___/_____ Type of Injury: _____ ☐ Lt☐Rt

D. Repetitive Injuries (Please list all repetitive injuries you've had in the past.)

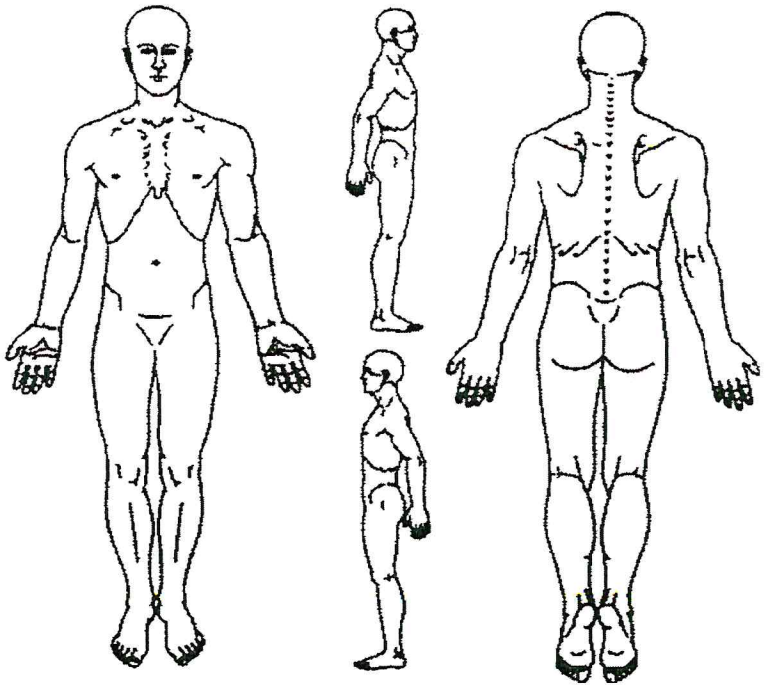
Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

Date:___/___/_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/___/_____ Type of Injury: _____ ☐ Lt☐Rt

*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



Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:** _____

Section 6: Present and Past Conditions

Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R & L***.

P = Past Health Issue **C** = Current Health Issue **N** = Never had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities	Location	tory	Other Conditions	Male
___ Hip ☐ Pain ☐ Stiff	☐ R ☐ L	___ Asthma	___ Headaches / Migraines	___ Impotence
___ Knee ☐ Pain ☐ Stiff	☐ R ☐ L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Foot ☐ Pain ☐ Stiff	☐ R ☐ L	___ Difficulty Breathing	___ Excessive Sweating	**Female**
___ Shoulder ☐ Pain ☐ Stiff	☐ R ☐ L	___ Lung Problems	___ Cancer & Type: _____	___ Menopausal Problem
___ Elbow ☐ Pain ☐ Stiff	☐ R ☐ L	___ COPD	___ Emotional / Mental Disorders	___ Menstrual Cycle Problems
		Digestion	___ Learning Disability	
___ Wrist ☐ Pain ☐ Stiff	☐ R ☐ L	___ Heartburn	___ Nervous / Irritable	
___ Jaw Pain ☐ Click ☐ Pop	☐ R ☐ L	___ Digestion Problems	___ Loss of Memory	**Social History**
___ Swollen or Painful Joints		___ Gallbladder Problems	___ Dizziness / Loss of Balance	
Spine		___ Colon Trouble	___ Arthritis	____ Smoking
___ Head / Shoulders Feel Heavy / Tired		___ Diarrhea / Constipation	___ Epilepsy / Convulsions	How much _____
___ Neck ☐ Pain ☐ Stiff	☐ R ☐ L	___ Hemorrhoids	___ Knocked Unconscious	How Often _____
___ Upper Back ☐ Pain ☐ Stiff	☐ R ☐ L	**Immune System**	___ Frequent Ear Infections	
___ Mid Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Skin Problems	___ Ringing in Ear R / L	____ Alcoholic Beverage Consumption
___ Low Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Sinus Problems/ Allergies	___ Hearing Loss R / L	Occurs_____
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:_____		___ Frequent Colds / Flu	___ Trouble Concentrating	____Recreational Drugs
		___ Anemia	___ AIDS / HIV	What Used_____
Other:_____		___ Other: _____	___ Fracture / Dislocation of Bones: _____	How Often_____
		Organ Problems or Dysfunction	___Other: _____	____Exercise
Numbness / Tingling or Pain In:		___ Diabetes	**Urinary Tract**	Type_____
___ Arm	☐ R ☐ L	___ Liver Trouble	___ Kidney Trouble	How Often_____
___ Hand /Fingers	☐ R ☐ L	___ Hepatitis	___ Frequent Urination	
___ Legs	☐ R ☐ L	___ High/Low Blood Pressure	___ Bedwetting	
___ Foot / Toes	☐ R ☐ L	___ Heart	___ Other:_____	

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

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:** _____

Section 7: Functional Assessment: Check any activities of life that your current conditions are affecting:

☐ Bending	☐ Carrying	☐ Climbing
☐ Concentrating	☐ Dancing	☐ Doing Chores
☐ Doing Computer Work	☐ Dressing	☐ Driving
☐ Gardening	☐ Lifting	☐ Performing Sexual Activity
☐ Playing Sports	☐ Pushing	☐ Reading
☐ Recreating	☐ Rolling over	☐ Running
☐ Shoveling	☐ Sitting	☐ Sitting to Standing
☐ Sleeping	☐ Standing	☐ Walking
☐ Watching TV	☐ Working	☐ Other: _____

Doctors Notes: _____

_____

Section 8: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: ***when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain).***

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident_____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

List any past hospitalizations and/or surgeries:

Surgeries: _____

List Hospitalizations Other Than Surgeries: _____

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

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Revised 1110812

NEW PATIENT CONSULTATION

Patient Name_____ DOB_____/_____/_____ Exam Date_____/_____/_____

Using **Black** or **Blue** ink, list **ALL** the **CURRENT** conditions you marked on Page 3 of your New Patient Paperwork; in **order of severity**.

Region of Present Complaint(s): List in order of Severity ***(Indicate if on Right side, Left Side, or Both)***	**Onset-When did you first notice this complaint?** (Use Weeks, Months, or Years.)	**Time-Have you experienced this previously? When? How long?**	**Quality-Describe your symptoms?** (examples: sharp, dull, burning, crushing)	**Provocation-What makes your symptoms better or worse?** (Specific examples: Lifting, Twisting, Bending, Sitting, Standing, Running, Walking.)	**How often do your symptoms bother you?** C=Constantly W=Weekly M=Monthly	**Severity of pain:** 0=No Pain 5=Moderate Pain 10=Worst Pain
EXAMPLE: SHOULDER PAIN; RIGHT SIDE	3 WEEKS AGO	Yes; 5 yrs ago; 1month	sharp	LIFTING; RUNNING	C	7

Doctors Notes:

_____

_____

Doctor's Signature _____ Date **Form Reviewed**: _____/_____/_____

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Elevation Health, LLC HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This authorization affects your rights regarding the privacy of your personal healthcare information.
Please read it carefully before signing.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be affected by my signing or not signing this release.

PLEASE SELECT OPTION A (or) B:

☐ **A.** I hereby authorize **Elevation Health**, to use and/or disclose the protected health information described below for the purpose(s) of treatment and care. **(Select one of the options below)**

____ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

____ I hereby authorize the release of my complete health record with EXCEPTION of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify):_____

Complete this Section if you checked either of the options above:
I authorize Elevation Health or its Business Associates to release all information to the following family members or friends

Name _____ Relationship_____
Name _____ Relationship_____

☐ **B**. Do not discuss/release my medical records or private information to anyone (including family members) or any entity. This option is not available for our minor patients; we must have written documentation indicating the adult caregiver(s) with whom we may discuss the child's care.

This authorization shall be in force until properly revoked by me at which time this authorization expires. To revoke my authorization, I must submit a Revocation of Authorization Notice to Elevation Health, Attn: Medical Records Manager.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law. Elevation Health and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA, federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____ _____
Print Name of Patient or Personal Representative Relationship to Patient DOB

You have the right to receive a copy of this HIPAA privacy authorization

Rev 09/07/16

Elevation Health, LLC

X-RAY CONSENT

The doctor has explained that the purposes of the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I understand that I must then make a determination, to seek additional advice, diagnosis, or treatment for the "unusual finding" from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

CONSENT TO EVALUATE A MINOR CHILD

I, Parent/Legal Guardian, of child, hereby grant permission for my child to receive chiropractic examinations and x-rays.

PREGNANCY RELEASE

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Print Patient Name DOB

_____ ____/____/____ ☐ *Witness*

Patient or Authorized person's Signature Date

Rev 09/07/16