Welcome to Medina Family Chiropractic and Acupuncture!

Please fill out this form and return it to the front desk.

Let us know if you have any questions!

Personal information	Date:	
First name:	Middle name:	Last name:
Preferred name:		
Address Street:		City:
	State:	Zip:
Social Security #:		
Preferred phone number:		
Email:		
Birthdate:	Age:	Marital status: M S W D
Occupation:	Employer:	
Number of children:		
How were you referred to us?		

Additional information		
Emergency contact name:		Phone:
Emergency contact relation:		
Primary Care Physician:		

Insurance information	Please provide a copy of your insurance card	
Insurance carrier:		
Name of policy holder:		**Date of birth of policy holder:**
Relationship of policy holder to you:		
Insured occupation/ employer:		
Secondary insurance carrier: (if any)		

Authorization and release: I authorize payment of insurance benefits directly to Medina Family Chiropractic. I authorize Dr. Heather Martin or Dr. Angela Hobbs to release all information necessary to communicate with personal physicians and other health care providers and mayors and to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Patient's name (printed): ____

Authorizing Signature: ________________________________ Date: ____________________

Guardian's name if applicable: ______________________________________

Personal information		
Race (circle one)	American Indian or Alaska Native	Native Hawaiian or Other Pacific Island
	Asian	White
	Black or African American	Other
Ethnicity (circle one)	Not Hispanic or Latino	Declined
	Hispanic or Latino	Unknown
Preferred Language:	English	
(circle one)	Spanish	
	Other: ________________	

For women only		
Most recent menstrual cycle:	_______/________/________	
Are you pregnant?	No	Yes
Total times pregnant:	**# Full Term deliveries:**	**# Deliveries before 37 weeks:**
# Vaginal deliveries:	**# C-section deliveries:**	

Where applicable, specify the approximate date of your most recent: (month/ year)	
Physical exam: _______/_______	**Dental Xray:** _______/_______
Spinal Xray: _______/_______	**CT Scan:** _______/_______
MRI: _______/_______	**Other scans or X-rays:** _______/_______

Complaint #1	**Area of complaint:**	
When did your symptoms begin? (circle one)	Today This week 3-6 months ago 6mo- 1 year	Within last 3 months More than 1 year
Which describes the frequency of your discomfort?	Constant Frequent	Intermittent Occasional
Which describes the *changes* in your discomfort during the day?	It is worse in the morning It changes with weather	It is worse in the afternoon It is worse at night It does not change
What helps *relieve* your discomfort?	Ice Heat	Medication Other: ______________________
What activities are limited by your discomfort?	Bending Bowel Movements Coughing Daily Routine Driving Getting up Lifting Lying down Pulling Pushing	Reading Sitting Sleeping Sneezing Standing Turning my head Urination Walking Working Other: ______________________
What does the discomfort feel like?		
Does the discomfort radiate to other areas?	No	Yes, please describe:
How would you rate your discomfort on a scale of 0-10?	0 1 2 3 4 5 No Pain Moderate Pain	6 7 8 9 10 Excruciating Pain
Have you ever had the same or similar condition?	No	Yes, please describe:

Complaint #2	**Area of complaint:**	
When did your symptoms begin? (circle one)	Today This week 3-6 months ago 6mo- 1 year	Within last 3 months More than 1 year
Which describes the frequency of your discomfort?	Constant Frequent	Intermittent Occasional
Which describes the *changes* in your discomfort during the day?	It is worse in the morning It changes with weather	It is worse in the afternoon It is worse at night It does not change
What helps *relieve* your discomfort?	Ice Heat	Medication Other: ______________________
What activities are limited by your discomfort?	Bending Bowel Movements Coughing Daily Routine Driving Getting up Lifting Lying down Pulling Pushing	Reading Sitting Sleeping Sneezing Standing Turning my head Urination Walking Working Other: ______________________
What does the discomfort feel like?		
Does the discomfort radiate to other areas?	No	Yes, please describe:
How would you rate your discomfort on a scale of 0-10?	0 1 2 3 4 5 No Pain Moderate Pain	6 7 8 9 10 Excruciating Pain
Have you ever had the same or similar condition?	No	Yes, please describe:

History of past illnesses		
History of stroke or hypertension?	No	Yes
Do you have a pacemaker?	No	Yes
Do you have a congenital condition?	No	Yes, please describe:
Do you have any allergies (medications, food, seasonal)?	No	Yes, please describe:

History of past illnesses		
Have you been diagnosed with cancer?	No	Yes, please describe:
Has a physician ever diagnosed you with an emotional/ mental condition?	No	Yes, please describe:
Please list any major illnesses, injuries, falls, auto accidents: List any dates if applicable		
Please list any surgeries and dates of surgeries:		
Please list the medications you are currently taking:		

Please circle if you have had the following conditions:		
Cardio-Pulmonary/ Circulatory	Anemia	Emphysema
	Hemophilia	Other Lung Disorder
	Hepatitis	Raynaud's Phenomenon
	Hypotension	Sickle Cell Anemia
	Asthma	Chronic Sinus Infections
	HIV/ AIDS	Other
Endocrine/ Gastrointestinal	Lupus	Rheumatoid Arthritis
	Scleroderma	Other Autoimmune Disorder
	Crohn's Disease	Epilepsy
	Headaches	Chronic Fatigue Syndrome
	Diabetes	Gallbladder problems
	Irritable Bowel Syndrome	Kidney Disease
	Liver Disease	Seizures
	Thyroid Dysfunction	Unexplained Weight Loss
Reproductive Health	Infertility	Cystitis
	Menopause	Prostate Enlargement
	Uterine Fibroid	Chronic Yeast Infections

Please circle if you have had the following conditions:		
Musculoskeletal	Arthritis	Gout
	Herniate disc	Muscular Dystrophy
	Numbness/ tingling in hands	Parkinson's Disease
	Multiple Sclerosis	Numbness/ tingling in feet
	Polio	Sciatica
	Osteoporosis	Pinched Nerve
	TMJ Dysfunction	Other:
Sensory Health	Blindness	Cataracts
	Deafness or Hearing Loss	Ear ringing
	Glaucoma	Eczema
	Meniere's Disease	Psoriasis
	Rhinitis	Sinusitis
	Tinnitus	Vertigo

Social Health		
Do you smoke?	No	Yes
(circle one)	Former smoker	If yes, start year:
	If former smoker, quit year:	If yes, how much?
Do you drink alcohol?	No	Yes
		If yes, how many per week?
Do you exercise regularly?	No	Yes
		If yes, how many days per week?

Please list all health conditions of immediate family:	
Conditions:	**Family member:**
Conditions:	**Family member:**
Conditions:	**Family member:**
Conditions:	**Family member:**
Family history is unknown _____	

I certify the information provided is accurate to the best of my knowledge:

Name (printed): ____

Signature: ____

Guardian (if applicable, printed): __________________________________

Date: ____

Informed Consent

Patient Name: ____
Clinic Name: ____Medina Family Chiropractic, LLC.________
Doctor's Name: __Heather A. Martin, D.C., _Angela M Hobbs, D.C._
Address: ____611 Highway 45 Bypass South, Medina, Tennessee 38355
Phone: ___731-783-0602____ Fax: ___731-783-0604_____

Treatments that may be administered include:

Spinal Manipulation: The doctor will use her hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "spinal manipulation" or "spinal adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), cost-vertebraeal strains and separation. Rare complications include, but are not limited to stroke. The most common complication is an ache or stiffness at the site of the adjustment.

We are aware of these complications, and in order to minimize their occurrence, we will take precautions. These precautions include, but are not limited to our taking a detailed clinical history of you and examining your any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell us when we take your clinical history.

Cupping: Cupping is a treatment of creating a vacuum in a glass or plastic cup, which is applied to the surface of the skin. After the cups are removed, there may be a slight discoloration of the skin (like a type of bruising). This usually resolves in a few days to a week. Very rarely, a slight burn or blister may appear due to the heat of suction.

By signing below, I acknowledge that:
I have read or have read to me the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss this consent with the doctor. I understand I can request more information at any time if desired. I consent to receiving treatment that involves the above procedures. I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

Date: _____________ Name (printed):____________________________
Signature: ________________________________
Signature of Parent or Guardian (if a minor): ________________________

Notice of Privacy Practices

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. I you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or Companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for that the Insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. A patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records of the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, service, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
10. I understand this authorization is valid from today until I ask for a change in this policy in writing.

Name (printed): ___________________________________ Date:__________________

Signature:_______________________________________

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Name (printed): ______________________________ Date: ___________________

Signature: __________________________________

Parent or Guardian Signature (if a minor): _____________________________

Parent or Guardian Name (if a minor): ________________________________

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

Please list below the names and relationships of people to whom you authorize the Practice to release PHI:

Name: __________________________ Relationship: _____________________

Name: __________________________ Relationship: _____________________

Name: __________________________ Relationship: _____________________