RESTORATION CHIROPRACTIC CO.

Welcome to our office! We are sure that you will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with today's examination procedures, which will determine how we can help you, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your body to function at its highest potential, free from interference and stress which causes dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in any way, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to be treated for whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you develop symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we receive from you is important. We use your health history, x-rays, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time of the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Ian McCann & Restoration Chiropractic Co. Staff

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	# OF CHILDREN:
EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

ABOUT YOUR SPOUSE

SPOUSE'S NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
SPOUSE'S EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	ZIP CODE:
EMPLOYER'S CITY/STATE:	POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ___YES __NO HOW OFTEN? _____
DO YOU DRINK ALCOHOL? ___YES __NO HOW OFTEN? _____
DO YOU DRINK COFFEE, TEA, OR SODA? __YES __NO

DO YOU EXERCISE REGULARLY? ___YES ___NO
IF YES, HOW OFTEN? _____
IF NO, IS THAT SOMETHING YOU'D LIKE TO IMPROVE? _____

DO YOU WEAR:
__ARCH SUPPORTS
__HEAL LIFTS __ SOLE LIFTS __INSOLES

RESTORATION CHIROPRACTIC CO.

2675 W 78th St.
Chanhassen, MN 55317
952-474-1544 (OFFICE)
952-474-1545 (FAX)

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

DID YOU SEE OR HEAR OF OUR OFFICE BECAUSE OF (CHECK ALL THAT APPLY):
__NEWSPAPER __SIGN __YELLOW PAGES
__MAILING __COMMUNITY EVENT __OTHER_____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? __YES __NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR OF CHIROPRACTIC'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
__CHRONIC DISCOMFORT __HOME INJURY
__SPORTS __AUTO __FALL __OTHER
PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? ___YES __NO

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
__GOTTEN WORSE __STAYED CONSTANT
__COME AND GONE

DOES THIS CONDITION INTERFERE WITH :
__SLEEP __DAILY ROUTINE __OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? __YES __NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
__YES __NO

NAME(S) OF DOCTOR(S):

TYPES OF TREATMENTS:

RESULTS:

ARE YOU AWARE THAT:

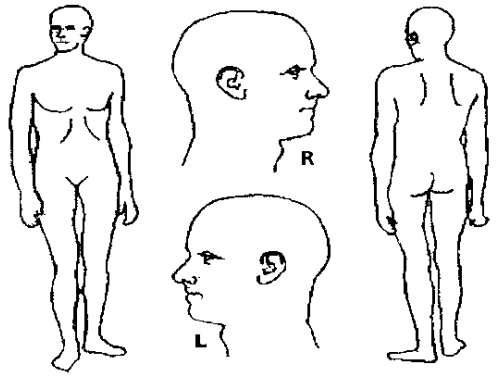
DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	___YES ___NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	___YES ___NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?	___YES ___NO
IF CHIROPRACTIC CARE STARTS AT BIRTH, ONE CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?	___YES ___NO

MEDICATIONS YOU TAKE

___CHOLESTEROL	___BLOOD PRESSURE	___STIMULANTS
___BLOOD THINNERS	___TRANQUILIZERS	___PAIN KILLERS
___ASPIRIN/ETC.	___MUSCLE RELAXERS	___INSULIN
___OTHER (list below)	___OTHER (list below)	___OTHER (list below)

___VITAMINS & SUPPLEMENTS:

MARK AREAS OF PAIN WITH AN "X"



YOUR CONCERNS

INSTRUCTIONS: Please circle the health concerns or conditions you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and nerve functions.

C1, C2, C3, C4
SORE THROAT
STIFF NECK
RADIATING ARM PAIN
HAND/FINGER NUMBNESS
ASTHMA
ALLERGIES
HIGH BLOOD PRESSURE
HEART CONDITIONS

C5, C6, C7, T1
HEADACHES
MIGRAINES
DIZZINESS
SINUS PROBLEMS
ALLERGIES
FATIGUE
HEAD COLDS
VISION PROBLEMS
DIFFICULTY CONCENTRATING
HEARINGPROBLEMS

T2, T3, T4, T5, T6, T7, T8, T9
MIDDLE BACK PAIN
CONGESTION
DIFFICULTY BREATHING
BRONCHITIS
PNEUMONIA
GALLBLADDER CONDITONS
STOMACH PROBLEMS
ULCERS
GASTRITIS
KIDNEY PROBLEMS

L1, L2, L3, L4, L5, S, A, C, R, A, L
CONSTIPATION
COLITIS
DIARRHEA
GAS PAIN
IRRITABLE BOWEL
BLADDER PROBLEMS
MENSTRUAL PROBLEMS
LOW BACK PAIN
PAIN OR NUMBNESS IN LEGS
REPRODUCTIVE ISSUES

OTHER:
_____
_____
_____
_____

HEALTH CONDITIONS

INSTRUCTIONS: *Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.*

☐SEVERE OR FREQUENT HEADACHES	☐THYROID PROBLEMS	☐PAIN IN ARMS/LEGS/HANDS	☐NUMBNESS
☐HEART SURGERY/PACEMAKER	☐SINUS PROBLEMS	☐LOW BLOOD PRESSURE	☐ALLERGIES
☐LOWER BACK PROBLEMS	☐HEPATITIS	☐RHEUMATIC FEVER	☐DIABETES
☐DIGESTIVE PROBLEMS	☐DIFFICULTY BREATHING	☐ULCERS/COLITIS	☐SURGERIES:
☐PAIN BETWEEN SHOULDERS	☐KIDNEY PROBLEMS	☐TUBERCULOSIS	☐ASTHMA
☐CONGENITAL HEART DEFECT	☐HIGH BLOOD PRESSURE	☐ARTHRITIS	☐LOSS OF SLEEP
☐FREQUENT NECK PAIN	☐ CHEMOTHERAPY	☐SHINGLES	☐DIZZINESS

FOR WOMEN ONLY:

ARE YOU PREGNANT?
___YES ___NO

IF YES, WHEN IS YOUR DUE DATE? _____

ARE YOU NURSING?
___YES ___NO

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.

PATIENT'S NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental, and social well being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. 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 subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS' SIGNATURE:	DATE:

PAYMENT AGREEMENT/USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctor(s) of Restoration Chiropractic Co., PA to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Restoration Chiropractic Co., PA will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Restoration Chiropractic Co., PA for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Restoration Chiropractic Co., PA will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Restoration Chiropractic Co., PA will be credited to my account upon receipt.

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

□ PATIENT □ SPOUSE □ PARENT □ WORKERS COMP □ AUTO INSURANCE

□ MEDICARE □ HEALTH INSURANCE

Signature:	Date:
Guardian or Spouse Authorizing Care's Signature:	Date:

Restoration Chiropractic Company PA

Patient Consent & Authorization for Use of Images, Video, and Testimonials

Purpose:
This form allows **Restoration Chiropractic Company PA** to use my image, video, voice, and/or testimonial for educational, promotional, and marketing purposes, including on social media (organic and paid advertising), websites, email campaigns, printed materials, and other digital or physical media. This authorization is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Information

Full Name: _____
Date of Birth: ____ / ____ / _____
Phone Number: _____
Email: _____

Authorization

I hereby authorize **Restoration Chiropractic Company PA**, its employees, contractors, and representatives, to:

1. **Capture** my likeness, image, voice, and/or testimonial in photographs, video, and/or audio recordings.

2. **Use, reproduce, publish, and distribute** these materials in any format (digital, print, or otherwise) for educational, marketing, or promotional purposes.

3. **Include** any relevant health information I choose to share verbally or in writing during recording, with the understanding that such information may be considered Protected Health Information (PHI) under HIPAA.

4. **Edit or modify** the materials as needed, while maintaining their intended meaning.

HIPAA & Confidentiality

I understand that:

- This authorization is voluntary and I am not required to sign it to receive treatment.
- My Protected Health Information (PHI) may be disclosed through these materials and could be viewed by the general public.
- Once disclosed, PHI may not be protected by HIPAA in the same way as within the clinic setting.
- I may revoke this authorization at any time in writing to **Restoration Chiropractic Company PA**, except to the extent that action has already been taken in reliance on this authorization.

Duration

This authorization will remain in effect **until revoked in writing** by me.

Acknowledgment & Release

By signing below, I release **Restoration Chiropractic Company PA**, its employees, and representatives from any liability arising from the use of my image, video, voice, and/or testimonial as described above.

Patient Signature: _____
Printed Name: _____
Date: ____ / ____ / _____

Practice Witness Signature: _____
Printed Name: _____
Date: ____ / ____ / _____
