Collins Chiropractic & Diagnostics 903 Northwest 9th Street Bentonville, Arkansas 72712
T: (479) 254-9355 F: (479) 254-9360 www.collinschironwa.com

Health History

Name _____ **Date of Birth** _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit — Date began

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other _____

Do you experience any of these general symptoms on a regular basis?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

_____

Outcome: _____

_____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

_____

What are your current health goals: _____

_____

FirstLine Therapy®
Lifestyle Medicine Programs by Metagenics

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Health History

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ☐+ ☐−

PAP ☐+ ☐−

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

Age of first period _____

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

_____

Health Habits

☐ Tobacco:

Cigarettes: # /day _____

Cigars: # /day _____

☐ Alcohol:

Wine: # glasses/d or wk _____

Liquor: # ounces/d or wk _____

Beer: # glasses/d or wk _____

☐ Caffeine:

Coffee: # 6 oz cups/d _____

Tea: # 6 oz cups/d _____

Soda w/caffeine: # cans/d _____

Other sources _____

☐ Water: # glasses/d _____

Exercise

- ☐ 5-7 days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wkk
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #days/wk _____
- ☐ Run, jog, other aerobic - #days/wk _____
- ☐ Weight lift: #days/wk _____
- ☐ Stretch: #days/wk _____

Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

☐ Skip meals (which ones) _____

_____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe) _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

I Would Like to:

Energy, Vitality

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

PATIENT NAME: DATE:

Pain Drawing

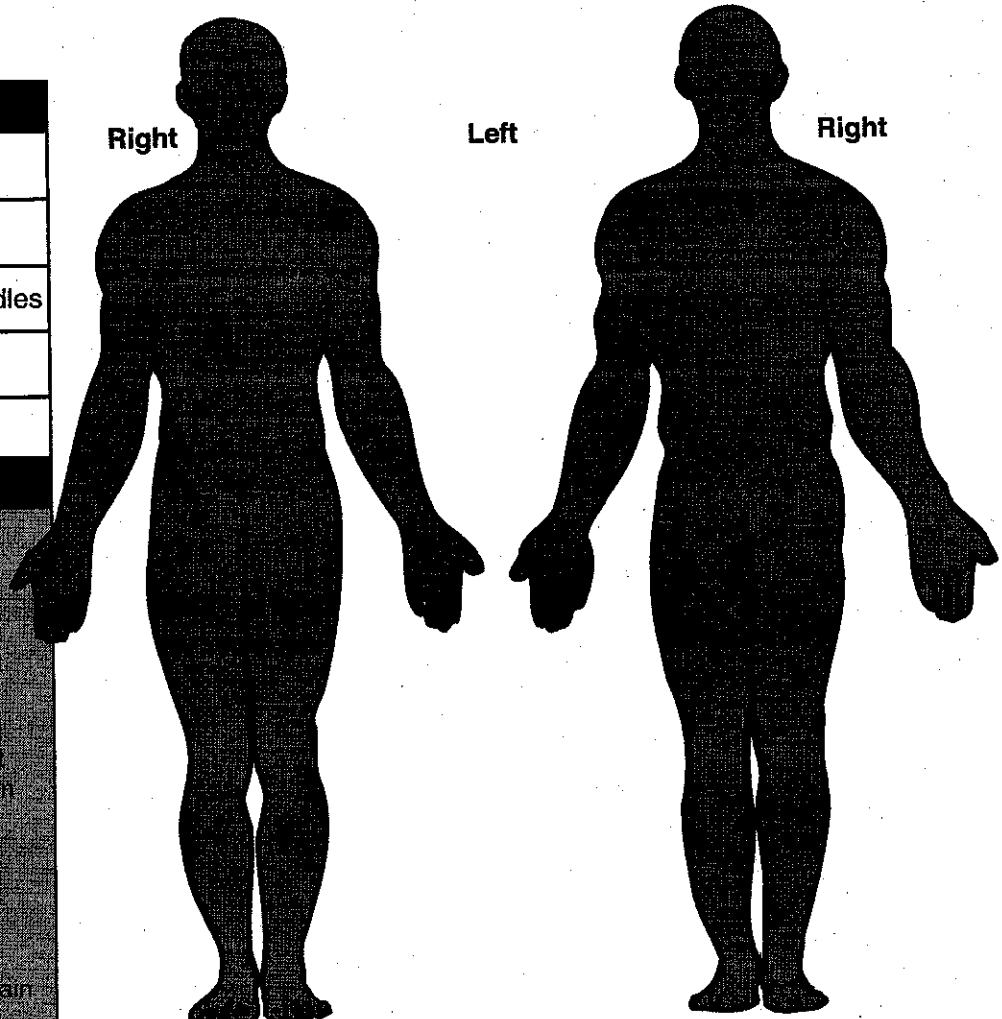
SOME PM&R PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

www.aapmr.org

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Collins Chiropractic and Diagnostics or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

COLLINS CHIROPRACTIC AND DIAGNOSTICS

FINANCIAL POLICIES and
PATIENT AGREEMENT
Effective January 02, 2019

Welcome to Collins Chiropractic & Diagnostics. We are committed to providing you the best available care. Your understanding of our Financial Policy and Patient Agreement is vital to the success of our relationship. Please review this information carefully. If you have any questions or concerns regarding these policies, our staff will be happy to help.

METHODS OF PAYMENT: We accept cash, checks or Visa/MasterCard. In most cases, our services and supplies are eligible for payment through Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs),and similar accounts. We will be happy to provide receipts and other documents to substantiate these expenses.

CASH ACCOUNTS: Patients are responsible for payment at the time of service unless arrangements are madewith our staff prior to the beginning of your care.

BENEFITS VERIFICATION: As a courtesy to you, we will attempt to verify your benefits prior to your initial evaluation. However, insurance carriers specify this verification is not a guarantee of payment, and the amount of patient responsibility (deductible and copays) is an estimate based upon available information. Services not covered or deemed not medically necessary by your plan are your responsibility. We strongly encourage you to call your insurance carrier to obtain your chiropractic benefits. Depending upon your health goals, the recommended treatment plan may exceed the limitations of your policy. Coverage is contingent upon your eligibility at the time of service.

INSURANCE FILING: We will file all claims with your primary and supplemental insurance carriers. Please provide us with complete and accurate personal and insurance information. Failure to do so may result in denial of claims by your insurance carrier. If you are denied, you are financially responsible for the outstanding balance. If we have an agreement with your insurance carrier, we will receive direct payment for covered services. After your insurance carrier has paid their portion of your claim, we will bill you for the outstanding financial responsibility.

DEDUCTIBLES AND COPAYS: According to the terms of your insurance plan, you are responsible for any predetermined deductibles and copayments at the time of service.

PERSONAL INJURY: If you have been involved in an automobile collision or other personal injury, please inform us before the beginning of care. Personal injury cases are accepted on the discretion of our staff. If we do not accept your case, we will refer you to an appropriate provider. If we accept your case, please provide us with all vital information regarding the case, including your automobile insurance carrier, any other appropriate insurance carrier, attorneys, and police reports. To ensure proper payment, we may ask that a medical lien be filed. Our staff will discuss with you how this affects you.

REFERRAL: If your insurance carrier requires a referral, it is your responsibility to obtain one from your primary care or referring physician.

BILLING SERVICE: If you wish to discuss your account and/or set up a financial arrangement, please contact our staff. Contact information is on your billing statement. Failure to pay or adhere to agreed financial arrangement may result in the account being turned over to an outside collection agency. You agree to pay all reasonable legal expenses necessary for the collection of any debt, including reasonable attorney fees. A possible $50 processing fee is assessed to the set-up of a financial arrangement. There is a $25 service charge on all returned checks.

BILLING STATEMENTS: We strive to mail billing statements regularly. We allow 60 days for your insurance company to respond to your claim. If they have not responded within 60 days, we will send you a bill for the outstanding amount and ask you begin making payments on your account while payment issues with your insurance carrier are addressed.

MEDICARE PATIENTS: For the 2015 calendar year, Medicare's deductible is $147. Once the deductible is met, Medicare covers services at 80% and you are responsible for 20% co-insurance. All secondary insurances to Medicare may pick up a portion, if not all, of the outstanding Medicare balances. You are responsible for all liability as laid out in your secondary health care plan. *Chiropractic adjustments are the only services covered by Medicare.* Other services in our clinic, such as required examinations, laboratory testing, and nutritional & lifestyle consultations are available on a cash basis.

MEDICAL RECORDS: We are happy to provide to you copies of your records. If you need copies, you must sign a medical records release form. We do not charge patients for copies of their own records. We charge a fee for records requested by a third party (lawyers, businesses, etc.).

MISSED, CANCELLED & LATE APPOINTMENTS: A minimum of 24 hours notice is required for cancellation of an appointment. This will allow time for the appointment slot to be filled by another patient. A missed appointment fee of $25 will be assessed if notice is not given. We understand that some circumstances leading to missed appointments cannot be avoided. Therefore, we will allow one missed appointment per calendar year without penalty. For established patients, if 3 appointments are missed in a calendar year, we reserve the right to require a credit card hold prior to scheduling your next appointment. If a new patient appointment is missed, a credit card hold will be required before rescheduling the new patient visit. If you are late for your appointment, please inform us as quickly as possible. You may be subject to the missed appointment policy.

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Collins Chiropractic & Diagnostics. I authorize the release of any relevant medical information that may be requested in order to process my claim. I authorize payment of medical benefits to Collins Chiropractic & Diagnostics. I am aware that if my insurance does not cover these services I will be responsible for charges.

I UNDERSTAND AND AGREE TO COMPLY WITH THE FINANCIAL POLICY EXPLAINED ABOVE.

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

Collins Chiropractic and Diagnostics

NAME:_____

I would like to receive my appointment reminders by:

☐ Phone call at the following number: _____

☐ Text at the following number: _____

☐ Email at the following email address: _____

I give permission for Collins Chiropractic and Diagnostics to email me at the following email

_____

for the following reasons:

☐ Exercise Home Program

☐ Patient Paperwork

☐ Change in nutrition program

☐ Clinic Announcements

☐ Report of Lab results as needed

☐ Scheduling appointments

☐ Other

Appointment reminders and private health information will be communicated to you only in the manners which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office Email and standard SMS text messaging are no confidential methods of communication and may be insecure.