New Patient Application

shift chiropractic

Date | First Name | Last Name

Gender | Date of Birth | Age

Live Healthy, Happy, & Pain Free

Home Phone | Cell Phone | Email Address

Address

City | State | ZIP Code

Occupation | Employer | Work Phone

☐ YES ☐ NO

Insurance | Provider Information

Marital Status | Spouse's Name

Spouse's Employer | Number of Children & Ages

How did you hear about our office? | Referred by

Emergency Contact: First Name Last Name

Phone Number | Relationship

3055 Cass Rd. Traverse City MI. 49684

(231) 846-8897

info@theshifttc.com

History of Complaint

Live Clear & Connected

Primary or Chief Complaint

What makes it worse/better?

When did it happen?

How did it happen

Second Complaint

What makes it worse/better?

When did it happen?

How did it happen?

Third Complaint

What makes it worse/better?

When did it happen?

How did it happen?

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Name of Previous Chiropractor

Date of Last Visit

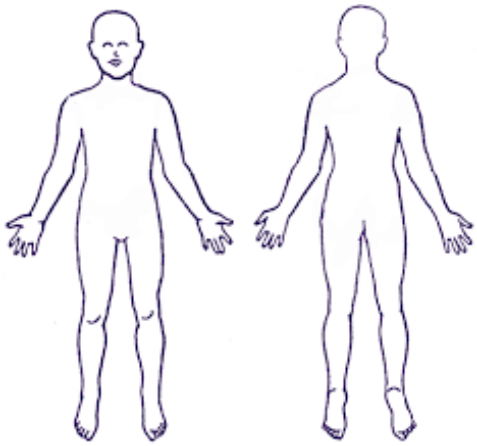
Have you seen any other Doctor for your primary complaint? If so, who?

What was the treatment?

What were the results?

Please indicate/label where you are experiencing pain or discomfort.

R = Radiating
A = Aching
B = Burning
N = Numbness/Tingling
D = Dull
S = Sharp/Stabbing



Review of Systems

Please mark P for in the past, C for currently have, or N for Never

_____ Headaches
_____ Pregnant
_____ Dizziness
_____ Prostate Problems
_____ Ulcers
_____ Loss of Balance
_____ Sexual Dysfunction
_____ TMJ/Jaw Pain
_____ Seizures
_____ Heart Problems
_____ Double Vision
_____ Chest Pain
_____ Lung Problems
_____ Eating Disorder
_____ Sleep Apnea
_____ Hepatitis (A, B, C)
_____ Kidney Trouble
_____ Fainting

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECTS:			
Carry Children/Groceries	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take:

Patient Signature

Today's Date

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Social History

Please List All Previous Surgeries and Dates:

☐ YES ☐ NO

Do you Smoke? | If so, how often?

☐ YES ☐ NO

Do you drink Alcohol Beverages? | If so, how often?

☐ YES ☐ NO

Do you have any hereditary conditions the Doctor should be aware of? | If so, please explain

Have you ever had any of the following?

Broken/Fractured Bones? If so, please explain:

Dislocations? If so, please explain:

Tumors? If so, please explain:

R.A? If so, please explain:

Cancer? If so, please explain:

Heart Attack? If so, please explain:

Diabetes? If so, please explain:

Stroke/TIA? If so, please explain:

SHIFT CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as irritation of a disc condition, and although rare, possible stroke, which occurs at a rate between one instance per one million to one per two million (less common than when you visit a medical doctor), have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments provided at Shift Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ • Witness Initials _____

Patient or Authorized Person's Signature Date

** 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.*

REGARDING: X-rays/Imaging Studies:

☐ 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.

_____ _____ • Witness Initials _____

Patient or Authorized Person's Signature Date

SHIFT CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.

2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.

3. For payment purposes - to obtain payment from your insurance company or any other collateral source.

4. For workers compensation purposes - to process a claim or aid in investigation.

5. Emergency - in the event of a medical emergency we may notify a family member.

6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.

7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.

8. For military, national security, prisoner and government benefits purposes.

9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.

10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.

11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.

2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.

3. To request mailings to an address different than residence.

4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

5. To inspect your records and receive one copy of your records at no charge, with notice in advance.

6. To request amendments to information. However, like restrictions, we are not required to agree to them.

7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

SHIFT CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Sheena Konas at 231-8468897 if she is unavailable, you may make an appointment with our team to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW Room 509F

HHH Building Washington DC 20201

I have received a copy of Shift Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____ DOB _____

Patient's Signature _____ Date _____

Witness _____ Date _____