



Great Choice Chiropractic

15810 S. 45th St. Suite 160
Ahwatukee, AZ 85048

Personal Health History

Today's Date: _____ / _____ / _____ Age: _____ Date of Birth: _____ / _____ / _____

Name: _____ Female Male Social Security #: _____ - _____ - _____

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

Home:(_____) Cell:(_____) Work:(_____)

E-mail Address: _____ @ _____

Height: _____ ft _____ in Weight: _____ lbs Primary care physician: _____

Occupation: _____ Employer: _____

Have you ever been to a Chiropractor? Yes No When? _____

How were you referred to Great Choice Chiropractic? _____

Current Health Condition

Present Complaint (Reason for today's visit): _____

Family Members

Spouse: _____ Age: _____

Child #1: _____ Age: _____

Child #2: _____ Age: _____

Child #3: _____ Age: _____

Child #4: _____ Age: _____

Previous Chiropractic Care?

Yes No Reason: _____

Yes No Reason: _____

Yes No Reason: _____

Yes No Reason: _____

Yes No Reason: _____

Check all that Apply to you:

1. Was Your Birth Traumatic?

- Long Delivery? _____
- Difficult Delivery? _____
- Forceps? _____
- Caesarian? _____
- Breach / cephalic? _____
- Homebirth? _____
- Mother given drugs? _____
- Induced Labor? _____

2. Growth and Development (Did you ever once...)

- Learn to care for your spine? _____
- Fall out of bed? _____
- Bang your head? _____
- Breastfeed? _____
- Childhood sickness? _____
- Have any Accidents? _____
- Have Surgery? _____
- Take Drugs or Medications? _____
- Fall while learning to walk? _____
- Bullied by your siblings? _____
- Chair pulled out when sitting? _____
- Fall down the stairs? _____
- Pulled by your arm? _____

Child abuse

- Spanking? _____
- Pulled ear / chin _____
- Other _____
- Experience other traumas? _____

Chiropractor's Comments

Name: _____

3. Current Health Habits (Did / do you...)

- Smoke? _____
- Drink alcohol? _____
- Diet (do you eat healthy foods?) _____
- Have you been in accidents? _____
- Have you had surgery and organs replaced/removed? _____

- Drugs? (Prescriptive or Non-Prescriptive)
- Have Teeth Problems?
- Have Eye Problems?
- Have Hearing Problems?
- Exercise regularly?
- Sleeping posture - - side stomach back
- Have sleeping problems? (Nightmares)?
- Have occupational stress?
- Have physical stress?
- Have mental stress?
- Have hobbies/sports injuries?

PERSONAL & FAMILY HISTORY

Number of Brothers and Sisters: _____ **F = Family S = Self** **Circle or check all that apply**

F S - AIDS / HIV	F S - Loss of memory	Difficulty with excessive:
F S - Allergies	F S - Loss of taste	<input type="checkbox"/> Standing
F S - Alzheimer's disease	F S - Loss of smell	<input type="checkbox"/> Sitting
F S - Anemia	F S - Mental dullness	<input type="checkbox"/> Lying
F S - Anxiety	F S - Mood swings	<input type="checkbox"/> Walking
F S - Arthritis	F S - Nausea / vomiting	<input type="checkbox"/> Riding
F S - Auto accident(s)	F S - Nervousness	<input type="checkbox"/> Bending: <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Forward <input type="checkbox"/> Back
F S - Other accidents / falls	F S - Neuritis	<input type="checkbox"/> Lifting: <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Repetitive
F S - Bed wetting	F S - Nose bleeds	<input type="checkbox"/> Other: _____
F S - Blood in urine / stool	F S - Osteoporosis	Numbness / tingling in:
F S - Blurred / Double vision	F S - Palpitation	<input type="checkbox"/> Arms: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Breast soreness	F S - Parkinson's disease	<input type="checkbox"/> Hands: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Cancer	F S - Ringing / Buzzing in ear(s)	<input type="checkbox"/> Fingers: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Change in bowel / urinary habits	F S - Shortness of breath	<input type="checkbox"/> Buttocks: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Chest pain	F S - Sleeping difficulty	<input type="checkbox"/> Legs: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Cold hands / feet	F S - Stress	<input type="checkbox"/> Feet: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Constipation	F S - Stroke	<input type="checkbox"/> Toes: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Convulsions / Epilepsy	F S - Tension	Pain / stiffness in:
F S - Depression	F S - Tremors	<input type="checkbox"/> Behind eyes
F S - Diabetes	F S - Ulcers	<input type="checkbox"/> Headaches
F S - Diarrhea	F S - Varicose veins	<input type="checkbox"/> Jaw-clicking (TMJ): <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Difficulty concentrating	F S - Visual disturbances	<input type="checkbox"/> Neck
F S - Dizziness	F S - Weight gain or loss	<input type="checkbox"/> Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Eating disorders	Trouble with:	<input type="checkbox"/> Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Extreme fatigue	<input type="checkbox"/> Balance / Equilibrium	<input type="checkbox"/> Hand / Wrist: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Eyes sensitive to light	<input type="checkbox"/> Sinus	<input type="checkbox"/> Fingers: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Eye strain / loss of focus	<input type="checkbox"/> Heart	<input type="checkbox"/> Upper back
F S - Fainting	<input type="checkbox"/> Liver	<input type="checkbox"/> Mid back (between shoulder blades)
F S - Frequent colds / flu	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Lower back
F S - Frequent ear infections	<input type="checkbox"/> Kidney	<input type="checkbox"/> When coughing or sneezing
F S - Hearing loss	<input type="checkbox"/> Digestion	<input type="checkbox"/> Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Heart disease	<input type="checkbox"/> Menstruation	<input type="checkbox"/> Knee: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Hemorrhoids	<input type="checkbox"/> Impotence	<input type="checkbox"/> Foot / Ankle: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - Hepatitis	<input type="checkbox"/> Prostate	<input type="checkbox"/> Toes: <input type="checkbox"/> Right <input type="checkbox"/> Left
F S - High / Low blood pressure		
F S - Irritability		

Notes: _____

Notice of Privacy Practices for Protected Health Information

Great Choice Chiropractic has my permission to discuss my: case history, payment history / schedule, and appointment scheduling with the following individuals:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and understand *Notice of Privacy Practices for Protected Health Information*.

Patient Printed Name

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient.



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(480) 704-6600

Informed Consent Form

I, _____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Greg Hauser, D.C., F.I.C.P.A. and **Great Choice Chiropractic.**

I have had an opportunity to discuss with the doctor and the clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that neither the practice of chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results had been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

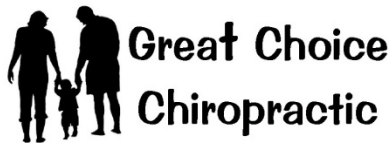
I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, stroke, dislocations, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or have had explained to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient Signature: _____

Date: _____

Patient name (print): _____



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Service Fee Schedule and Financial Policy

<u>Service</u>	<u>Regular Fee</u>	<u>Time of Service Discounted Fee</u>
Initial Consultation	No charge	No charge
Initial Exam with Computer Scans	\$110-225	\$60-175
X-Rays (per view)	\$30- 55 per view	\$30-55 per series
Reporting of Doctor's Findings	\$50-80	\$50
Periodic Dynamic Exam	\$60	\$40
Adjustment	\$55-95	\$55
Therapeutic / Rehabilitative Services	\$30-40 per service	\$30-40 per visit
Individual Lifestyle Adjustment Plans	Not applicable	\$50 - \$200 per month
Family Lifestyle Adjustments Plans	Not applicable	\$100+ per month

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best Chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Lifestyle Adjustment Plans (LAP). Details of these plans will be discussed with you during your Chiropractic report. **Please read and initial both of the following fee options:**

_____ Regular Fees: If you have health insurance that covers Chiropractic and choose to use it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Any and all insurance payments sent to you and accompanying paperwork will be brought to our office for proper processing of claims and distribution of funds.

_____ Time of Service Discounted Fees: If you do not have health insurance, choose not to use your health insurance, or are participating in a Lifestyle Adjustment Plan, you will be eligible for the Time of Service Discounted Fees above. You may request a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for Chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the discounted fees again.

*Please note that all "health insurance" coverage (including Medicare) is NOT allowed to be used for Lifestyle Adjustment Plans (see your insurance contract for details).

Regardless of the financial arrangements or method of payment, it is **Great Choice Chiropractic's policy to **collect only \$79 on the first visit**, which will be applied toward the balance of the first visit charges.

Patient signature

Date