GENERAL INFORMATION

Please print clearly. Information in confidential.

Date: ______________

Patient First Name: _________________ Last Name: _________________ MI: __________

Date of Birth: ______________ Age: ______ Sex: ☐ Male ☐ Female

Address: _____________________________ City: _________________ State: _______ Zip: ___________

Occupation: ___________________ Employer: ___________________ Phone (Work): _________________

Phone (Cell): _________________ Email: ______________________

Are You: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouses Name: ________________________

Spouses Phone: ________________________ Number of Children: ________________

Emergency Contact Info: ____

How did you hear about us?: ☐ Online Search ☐ Referral ☐ Event ☐ Social Media ☐ Other

Have you had previous Chiropractic care? ☐ Yes ☐ No Chiropractor's Name: ________________________

Were you given any type of treatment plan, home care stretching/strengthening program to assist your recovery?

☐ Yes ☐ No If yes, please describe: ___________________________________

Did you follow it? ☐ Yes ☐ No If not, why? _____________________________

Why are you changing Chiropractors? _____________________________

Who is your primary care physician? _____________________________ Phone: _________________

May we update your medical doctor regarding your treatment in our office? ☐ Yes ☐ No

Date of last physical/exam? ________________________

Please list all vitamins/medications that you currently take (including over the counter):

____

Dosage of each medication:

____

Females: Are you pregnant: ☐ Yes ☐ No

Can we email you periodically about practice updates? ☐ Yes ☐ No

CLIENT INTAKE FORM

What is your **PRIMARY COMPLAINT** that brings you into our office?____

____

Date when symptoms first appeared____________________ What area of the body?____________________________

How did it begin?____

Type of pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Other

Do you know the cause? ☐ Yes ☐ No If so, what?_________________________

Do you have numbness or tingling? ☐ Yes ☐ No If so, where? _________________________

Does the pain radiate into: ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other _____________ ☐ Does not radiate

How often do you experience these symptoms? ☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

Have you ever experience the same or similar symptoms at any other time? ☐ Yes ☐ No If so, when?__________

What makes symptoms worse?________________________

Are you taking any medication to currently relieve the symptoms of this problem? Including OTC. ☐ Yes ☐ No

If yes, what? ☐ Nerve Pills ☐ Pain Pills ☐ Muscle Relaxer ☐ Blood Pressure ☐ Other________________

Is there anything else that relieves your symptoms?____

Do any family members suffer from the same complaint? ☐ Yes ☐ No If so, who? _______________________

Have you been to another doctor for this problem? ☐ Yes ☐ No If so, who/where?__________________________

Are your current symptoms accident related (auto, work or other)? ☐ Yes ☐ No If yes, please describe:

____

When did this accident occur? ☐ Past year ☐ Past 5 years ☐ Over 5 years

Please list all surgeries, the type and when it occurred:

____

____

Please list other injuries, accidents, falls, etc. that you have experienced other than your primary complaint:

____

____

HEALTH HISTORY

Please indicate any health conditions you have or are currently experiencing

- ☐ Fractured bones (please describe)______________
- ☐ Auto Accident(s)
  - ☐ 0-1 yrs ago ______________
  - ☐ 1-5 yrs ago ______________
  - ☐ 5+ yrs ago ______________
- ☐ Other accidents, falls. Describe:______________
  ____
- ☐ Headaches:
  - ☐ Tension ☐ Migraine ☐ Dizziness
- ☐ Blurred or Double Vision
- ☐ Ringing in ears
- ☐ Hearing Loss (circle one) R L Both
- ☐ Jaw Pain or Clicking (circle one) R L Both
- ☐ Neck Pain or Stiffness (circle one) R L Both
- ☐ Shoulder Pain (circle one) R L Both
- ☐ Upper Back Pain/Stiffness
- ☐ Numbness/Tingling/Pain (circle one) R L Both
  - ☐ Arms ☐ Hands ☐ Fingers
- ☐ Numbness/Tingling/Pain (circle one) R L Both
  - ☐ Buttocks ☐ Legs ☐ Feet ☐ Toes
- ☐ Difficulty in Excessive Standing, Sitting, Riding Bending, Twisting, Lifting (circle one)

- ☐ Eating Disorders
- ☐ Under Stress
- ☐ Depression
- ☐ Irritability
- ☐ Trouble Concentrating
- ☐ ADD / ADHD
- ☐ Learning Disability
- ☐ Skin Problems
- ☐ Mood Changes
- ☐ Anemia
- ☐ Bedwetting
- ☐ Ear Infections
- ☐ Chest Pain
- ☐ Asthma
- ☐ Heart Problems
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Liver Problems
- ☐ Trouble Sleeping
- ☐ Frequent Colds, Flu

- ☐ Foot Trouble (circle one) R L Both
- ☐ Diabetes - Type 1 or Type 2 (circle one)
- ☐ Lower Back Pain/Stiffness
- ☐ Convulsions, Epilepsy
- ☐ Pain with Cough or Sneeze
- ☐ Gall Bladder Problems
- ☐ Digestive Problems
- ☐ Impotence
- ☐ Kidney Trouble
- ☐ Menstrual Problems
- ☐ Pregnant (currently)
- ☐ Fertility Problems
- ☐ HIV, AIDS
- ☐ Cancer
- ☐ Arthritis
- ☐ Allergy, Sinus
- ☐ Hip Pain (circle one) R L Both
- ☐ Ulcers
- ☐ Hemorrhoids
- ☐ Prostate Problems
- ☐ Others, please specify
  ____

Family History - Please list significant diseases/conditions experienced by immediate family members:

____

____

Health Habits:

Do you smoke or have you ever smoked in the past? ☐ Yes ☐ No If yes, please describe ________________________

Do you consume alcohol? ☐ Yes ☐ No Do you consume caffeine? ☐ Yes ☐ No

Do you have a high stress level? ☐ Yes ☐ No If yes, please list reasons: ________________________

Do you exercise? ☐ Yes ☐ No If yes, how many times per week and what type?________________________

PRIVACY PRACTICES

I have received or reviewed the privacy practice notice for HHFC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

______________________________	______________________________
Patient Signature	Date

____

Printed Name

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
Authorized to speak with regarding care	Relationship/Phone # of individual(s)

________ OK to leave detailed messages on primary #

________ Do NOT leave detailed messages on primary #

FINANCIAL POLICIES AND TERMS OF ACCEPTANCE OF CARE

It is important for each patient to understand both the objectives and methods of chiropractic care to prevent any confusion or problems in the future. Please take time to review the information below.

Adjustment: An adjustment is the specific application of forces and physiotherapy to facilitate the reduction or correction of spinal misalignment (subluxation).

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes the alteration of both muscle and nerve function. This will interfere with the transmission of nerve impulses which can cause the lessening of the body's ability to function properly.

Our office does not diagnose or treat any diseases or conditions other than Vertebral Subluxation. However, if during the course of an examination we find a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend you seek out the services of your primary care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding the treatment prescribed by others.

All visit charges are payable when services are rendered. Healing Hands Family Chiropractic requires a courtesy call of giving at least 24 hours notice in the event you cannot keep your scheduled appointment. If we do not receive notification of a cancellation of your scheduled appointment within the 24 hour notice, your appointment will be considered a NO SHOW. We reserve the right to charge the full amount of the missed appointment. It is also our policy that appointments remain punctual; you will be given 10 minute after the start of your scheduled appointment before you are considered a NO SHOW. Healing Hands Family Chiropractic also reserves the right to reschedule any appointments where the patient shows up after the 10 minute start of their appointment and you will be charged the full amount of the missed appointment.

We also offer multiple ways to pay including cash, check or credit card. Please be aware that if you choose to pay by credit or debit card, there will be an additional 3% convenience fee for all transactions.

I (please print)____ have read and fully understand the above Policies and Terms of Acceptance, and hereby grant permission to receive chiropractic services.

Patient signature: ____
Date:____________

EXPLANATION OF PIEZOWAVE -MYACT (MYOFASCIAL ACOUSTIC COMPRESSION THERAPY)

PiezoWave- MyACT is Acoustic Compression Therapy which uses sound waves to REMODELING TISSUE AT THE CELLULAR LEVEL by addressing a large variety of conditions including, scar tissue, calcification, tendinopathy, bursitis, capsulation's and so much more.

PiezoWave technology is based off the same conceptual technology as lithotripsy to break up kidney stones just lower more pinpoint energy. A good way to explain it to your patients is to think of submarine at the bottom of the ocean, they cannot see in front of them so they send out sonar waves (sound waves) to find anything that may be in front of the submarine and when it finds something it sends a signal back to the sub. This is the same idea or concept with MyACT.

The patient does not feel anything during treatments when you are over healthy/hydrated tissue. The patient will feel a dull aching feeling when you pass over any compromised tissue making it easy to know that you are on correct location so you can address the soft tissue injury directly.

One of many unique things about the PiezoWave is that you get a biomechanical feedback from the patient while doing the treatment so you know you have located the correct spot. When you find the compromised tissue the patient feels a dull aching feeling almost like a toothache or pushing on a bruise.

At this point you ask the patient on a scale of 1-10 what is your pain level. You want the patient to be around 5,6, or 7.. If the patient feels 8,9, or 10 unless they can tolerate it you would move off the injury site and come back in 30 seconds for the nerves signals to relax. After you get the patient to a 5, 6, or 7 you will deliver several pulses until the patient starts to feel the dull aching feeling diminishing down to a 1 or 2 and this will happen in "about" 30 to 45 seconds.

The difference between the therapy sources are:

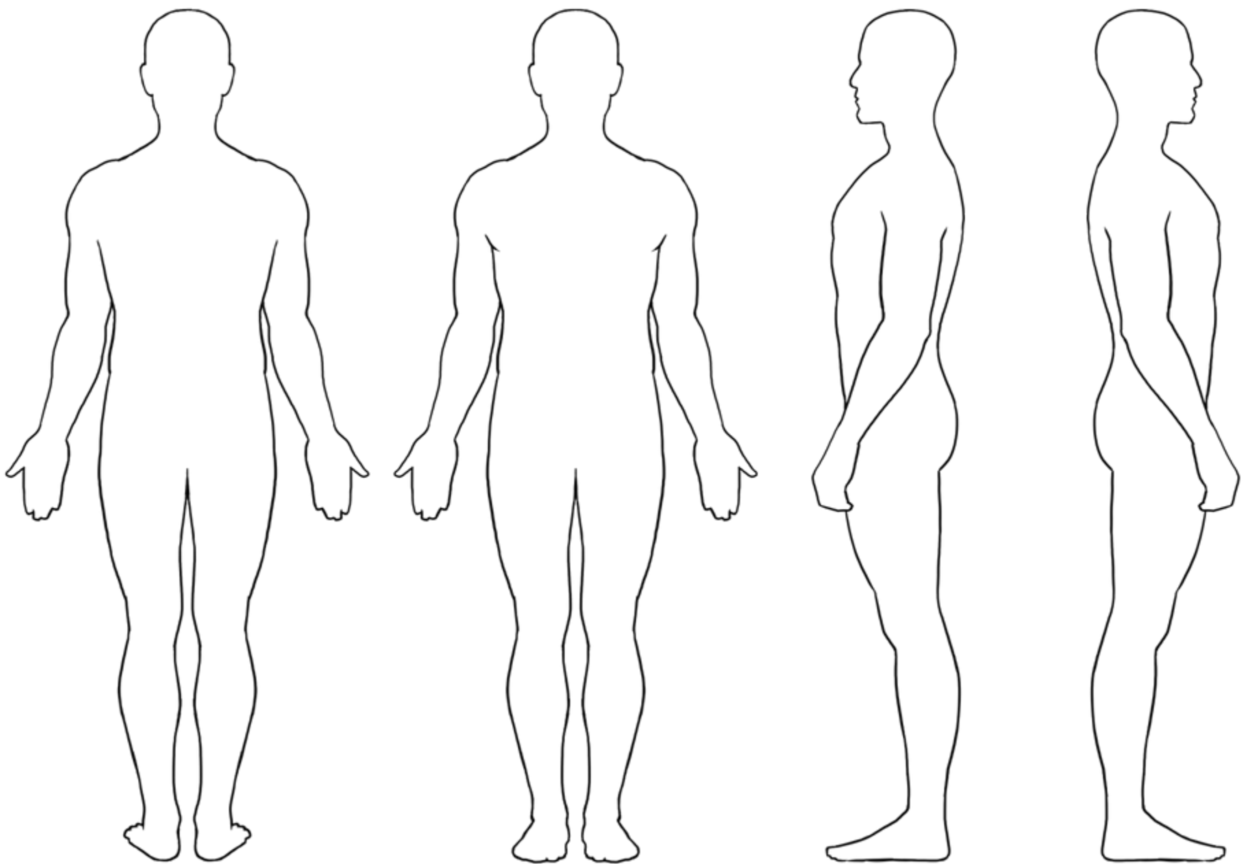
1. The pinpoint (F7G3) is exactly that pinpoint and has 250 piezo crystals in one layer and is ideal for most treatments and especially insertion points and precise treatments.
2. . The Linear (FBL) therapy source covers more surface area linear wise and had 450 piezo crystal in two layers giving more energy output to cover the larger treatment area. Linear is ideal for larger muscle groups such as quads, hamstrings, etc. Some of our sports teams use the linear to wand the area to increase blood flow for pre and post workouts.

With the PiezoWave there is two adjustments on the control unit for frequency of pulses per second ranging from 1-8 pulses per second and the other is the intensity level from (.1 up to 18) most people do not get above 10 so there is more than enough energy output and pulses per second with the PiezoWave. Most treatments are around 8-10 mins averaging 1,000 - 2,500 pulses.

MYOFASCIAL ACOUSTIC COMPRESSION THERAPY QUESTIONNAIRE

Where Is Your Pain - Pretreatment

Please mark an X where your pain is NOW:



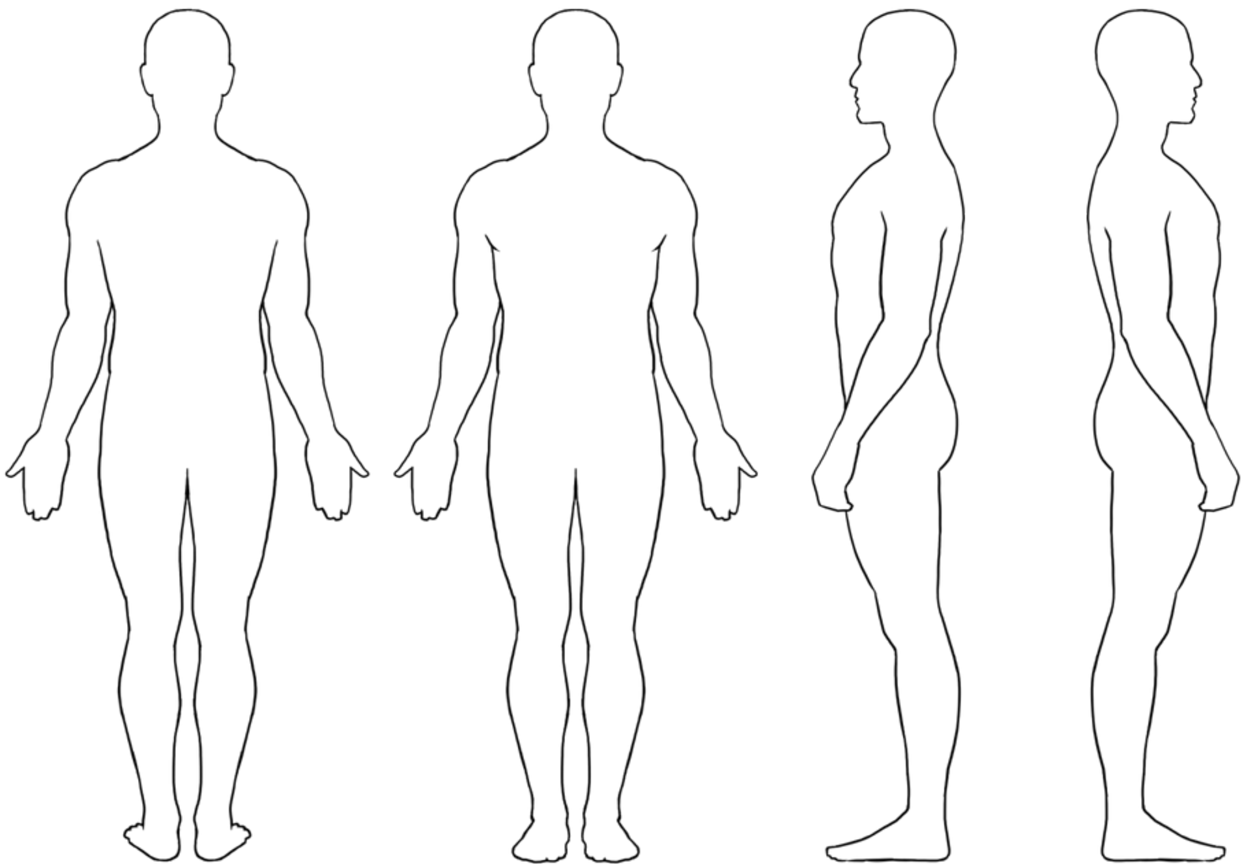
How severe is your pain NOW?

No pain **0 1 2 3 4 5 6 7 8 9 10** **Extreme Pain**

MYOFASCIAL ACOUSTIC COMPRESSION THERAPY QUESTIONNAIRE

Where Is Your Pain - POST TREATMENT

Please mark an X where your pain is POST-TREATMENT:



How severe is your pain POST TREATMENT?

No pain **0 1 2 3 4 5 6 7 8 9 10** **Extreme Pain**

CONTRADICTIONS

Pregnancy	Yes	No
Active Cancer/malignancy	Yes	No
Local infection/acute inflammation of bone/tissue	Yes	No
Blood dyscrasia, blood thinners, or bleeding tendencies	Yes	No
Pacemaker/ICD (implantable cardioverter defibrillators)	Yes	No
Any implanted device that releases substances or medications to the periphery (sich as insulin or morphine pump) and is implanted in the area to be treated with (Acoustic Compression Therapy). Orthopedic implants are not included in this section	Yes	No
Lung tissue, or crown of the cranium	Yes	No
Any recent injections to the area of treatment such as cortisone, PRP	Yes	No

I have read and understood the above contraindications and I consent to treatment for Acoustic Compression Therapy. The information about the procedure(s) has been provided to me both verbally and in writing and I have had the opportunity to ask questions and I am aware the above contraindications does not necessarily mean I am excluded from the treatment, but opens up the conversation of the potential approach to the treatment. All questions which I have presented have been answered to my satisfaction. I consent to receive Acoustic Compression Therapy.

Patient signature: ____

INFORMED CONSENT FORM

The primary treatment used by the doctors at Healing Hands Family Chiropractic is spinal manipulative therapy.

The nature of the Chiropractic Adjustment: The doctors at Healing Hands Family Chiropractic may use a mechanical instrument on your body to move your joints; they may also use their hands or other mechanical devices to work on the joints and soft tissue of your body or other modes of physiotherapy and supportive therapies. During treatment you may hear a clicking associated with the use of the mechanical instrument and may feel a sense of movement in your joints, or a release of your soft tissue.

The material risk inherent in a Chiropractic adjustment: Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications are considered rare but patients may experience fractures, disc injuries, dislocations, muscle strain, ligament sprain, cervical myelopathy, and/or Horner's Syndrome and stroke. Some people have documented feelings of stiffness or soreness in the days following treatment.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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 on the facts known then, is in my best interest. The doctors at Healing Hands Family Chiropractic will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform them.

I also understand and am informed that there may be other treatment options available for my condition besides chiropractic procedures. These treatment options can include, but are not limited to, self-administered, over-the counter analgesics, rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms.

I also understand and I have been informed that if seeking pregnancy care that the doctors at Healing Hands Family Chiropractic will NOT "turn" the fetus in utero or will be practicing any other types of obstetrical or gynecological care. I understand and I have been informed that I am seeking care and treatment of musculoskeletal conditions associated with pregnancy only.

If you do not fully understand the above or have questions about anything mentioned in this document, please do NOT sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Healing Hands Family Chiropractic.

I (please print)____ have read and fully understand and agree to both the *informed consent to treat & authorization of care.*

Patient Signature: _________________________________ Date:________________