



FOUNTAIN OF LIFE CHIROSTUDIO

DR. SHANNON BLUMHARDT
FAMILY CHIROPRACTOR

OPTIMAL HEALTH
FOR FAMILIES

PERSONAL AND FAMILY HEALTH HISTORY

TODAY'S DATE: _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone: (H) _____ (W) _____
Cell: _____
E-mail _____
Date of Birth _____ (Age _____)
Height: _____ Weight: _____
Preferred Name _____

How did you hear about our office?

Social Security # _____
Occupation _____
Employer _____
Marital Status S M DP D W Sep Eng
Spouse/DP/Fiancé's Name _____
Spouse/DP/Fiancé's Occupation _____
Are you or might you be pregnant? ____ Y ____ N

Names of Children and Ages Have they had previous Chiropractic Care?
Name _____ Age _____ Yes ___ No ___ Reason _____
Name _____ Age _____ Yes ___ No ___ Reason _____
Name _____ Age _____ Yes ___ No ___ Reason _____
Name _____ Age _____ Yes ___ No ___ Reason _____

Why this form is important - You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove this interference to your natural health expression so that you and your family may have the opportunity for a lifetime of health and happiness.

Circle All That Apply Patient Child#1 Child#2 Child #3 Child #4 Comments/Details

Table with 6 columns: Question, Patient, Child#1, Child#2, Child #3, Child #4, Comments/Details. Row 1: 1. Was Your Birth Traumatic? (Circle if you know...)

2. Growth and Development (Childhood Years: Ages 0-17 years) - If Yes, please write details

Did you ever...
Have chiropractic care? Y / N
Fall while learning to walk? Y / N
Have any other falls or accidents? Y / N
Have surgery? (dates, type) Y / N
Have recurrent childhood illness/sickness? Y / N
Take drugs (i.e. antibiotics, vaccines)? Y / N
Experience other traumas/ stress? Y / N



FOUNTAIN OF LIFE CHIROSTUDIO

3. Current Health Habits (Adult Years: Ages 18 to present) – If Yes, please write details

Did/do you...

Utilize chiropractic care (prior to today)? Y / N
Eat healthy foods regularly? Y / N
Drink 8-10 cups of water daily? (#cups/day) Y / N
Exercise regularly? (type, duration) Y / N
Smoke? (how much/week) Y / N
Drink? (# drinks/week) Y / N
Have you been in car accidents? (dates) Y / N
Utilize drugs? (list prescription/non-prescript.) Y / N
Have surgery? (dates, type) Y / N
Had organs replaced/removed? Y / N
Have Teeth Problems? Y / N
Have Eye Problems? Y / N
Have high mental stress? Y / N
Have high physical stress? Y / N
Have hobby or sports injuries? (dates, injury) Y / N
Have sleeping problems? Y / N
Sleeping position: side; stomach; back?
Number and type of pillows used?
Nutritional Supplements? (list all) Y / N

What are your current health goals? (ie: Get out of pain, lose weight, eat healthier, quit smoking, walk 5 miles, etc.)

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Present complaint (Reason for your visit today)

Pain or problem started how and when?

Pain or problem occurred before?

What activities make your condition / pain worse?

What activities make your condition / pain better?

How long has it been since your really felt good?

If you have pain, is it... sharp dull radiating constant intermittent mild moderate mod-severe severe

Since it began, is it... about the same variable getting better getting worse?

What time of day is it worst? waking at work evening at night variable constant

Does it interfere with... work sleep walking sitting exercise other?

Is this condition getting progressively worse?

Other Doctors seen for this condition

Any home remedies?

Who is your primary health care physician? Phone:

Would you like us to provide your MD with periodical reports to keep them up to date with your progress? Y N

Have you been adjusted by a chiropractor before? Yes No

Who: Date of last adjustment:

Frequency of visits: times a week/month How long did you receive care?



FOUNTAIN OF LIFE CHIROSTUDIO

OTHER SYMPTOMS (even if they do not seem related to your current condition):

- AIDS / HIV
- Allergies / Sinus Problems
- Anxiety / Nervousness
- Arm / Shoulder pain
- Arthritis / Joint Problems
- Asthma / Shortness of Breath
- Bladder Problems
- Cancer
- Chest Pains
- Chronic Fatigue
- Crohn's Disease
- Cold Hands / Feet
- Cold Sweats
- Constipation / Diarrhea
- Deafness
- Depression
- Diabetes
- Digestion problems
- Other _____
- Earache
- Ear ringing / Buzzing
- Epilepsy
- Eye problems / Vision Loss
- Foot/Ankle problems
- Headaches / Migraines
- Heartburn / Reflux
- Heart Disease / Problems
- Hemorrhoids
- Herniated Disk
- High Blood Pressure
- Hot Flashes
- Infertility / Impotence
- Insomnia
- Irregular cycle
- Irritability / Mood swings
- Jaw / TMJ problems
- Kidney Problems
- Leg Pain
- Loss of Balance
- Loss of Smell / Taste
- Low Back Pain
- Menopause
- Multiple Sclerosis
- Neck pain / Stiffness
- Numbness in Arms / Fingers
- Numbness in Feet / Toes
- Osteoporosis
- Pins & Needles in Arms/Hands
- Pins & Needles in Legs
- Plantar Fasciitis
- PMS / Menstrual cramps
- Poor Circulation
- Problems Urinating
- Prostate Problems
- Recurring Infection
- Rheumatoid Arthritis
- Sciatica
- Shingles
- Shoulder Stiffness / Pain
- Sinus Infection
- Stomach Upset
- Stroke
- Tension across Shoulder Blades
- Tension / Stress
- Thyroid Problems
- Ulcerative Colitis
- Ulcers
- Venereal Disease
- Vertigo/Dizziness
- Vision Changes/Vision Loss

What side effects have you experienced from any drugs/surgery? _____
Is there a family history of: _____

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How old was your oldest living relative? _____ You have their genes. Adjust your lifestyle today and enjoy the quality of life you deserve.

As a result of my Chiropractic Care, I would like to: (Please check all that apply)

- Feel better quickly*
- Have a healthier body by keeping my nerve system healthy*
- Have a healthier spine*
- Live a healthier, more active lifestyle*

The above stated is true.

We are committed to providing you with the best chiropractic care possible in a caring environment, and have established financial policies consistent with that goal. You are expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Our recommendations for care are individually designed to help each practice member reach his or her full genetic health potential. They are not based on what your insurance company will or will not pay. Patients are ultimately responsible for all charges in this office, including any services which exceed insurance policy limitations for specific number of visits or dollar amounts. Your signature below indicates understanding of this policy and gives us permission to release your health information to your insurance company (if applicable), allows them to make any contributions to your care directly to our office, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you or on your behalf.

Signature Date

Parent Signature (if patient is a minor) Date



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Blumhardt Family Chiropractic, PC, dba

Fountain of Life ChiroStudio

Consent for Purposes of Treatment, Payment, and Healthcare Operations

TERMS OF SERVICE

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. 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 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 subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I, (Printed name) _____ (Signature) _____ undertake chiropractic services on the understanding of and agreement with, the above explanation. _____ (Date).

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____ (Print name) give permission for my child to receive chiropractic care.

Blumhardt Family Chiropractic, PC, dba Fountain of Life ChiroStudio
Health Information Form

THE PERSON IDENTIFIED AUTHORIZES Fountain of Life ChiroStudio, TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Fountain of Life ChiroStudio to use my address, phone number, e-mail, and records to contact me with reservation reminders, missed reservations, greeting cards, as well as information about chiropractic care.
2. If Fountain of Life ChiroStudio contacts me by phone; I give them permission to leave a phone message on my answering machine or voice mail.
3. I give Fountain of Life ChiroStudio permission to adjust me in an open room where other people are also being adjusted. I am aware that other persons in the office may overhear some of my health information during the course of care. Should I need to speak with the doctors at any time in private: the staff at Fountain of Life will provide a room for these conversations. I also consent to signing the guest book every time and understand that others may view it.
4. If you have insurance benefits and elect to use these benefits, we will use your information to process your insurance claims electronically, by fax or by mail. The following release gives permission to use your information to process your claim. I also authorize payment of medical benefits to Fountain of Life ChiroStudio for services rendered.
5. To help share chiropractic miracles and celebrate special occasions, I consent to my photograph and name being used in the office for recognition.
6. By signing this form you are giving Fountain of Life ChiroStudio permission to use and disclose your health information in accordance with the directives listed above and in Fountain of Life's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fountain of Life ChiroStudio. The Notice of Privacy Practices for Fountain of Life ChiroStudio is also provided in the wellness resource center and on Fountain of Life's website at www.FountainWellness.com.

Signature _____ Date _____

If a minor, or represented by another party
Signature of Personal Representative _____



FOUNTAIN OF LIFE CHIROSTUDIO
OFFICE FEE SCHEDULE AND FINANCIAL POLICY
 (FEES SUBJECT TO CHANGE WITH 30 DAYS POSTED NOTICE)

☞ CONSULTATION	NO CHARGE	☞ EXTREMITY ADJUSTMENT	50
☞ INITIAL EXAM	115-175	☞ ICE PACK	25
☞ REPORT OF FINDINGS	NO CHARGE	☞ HYDROMASSAGE	35
☞ PROGRESS EXAM	95-115	☞ THERAPEUTIC EXERCISE	45
☞ CHIROPRACTIC ADJUSTMENT	60-75	☞ MANUAL THERAPY	55

FINANCIAL POLICY

We are committed to providing you with the best chiropractic care possible in a caring environment, and have established financial policies consistent with that goal. You are expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Details of available investment options, called Active Life Plans, will be discussed with you when the Doctor goes over your specific recommendations for care. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Patient is responsible for any and all expenses incurred in the collection of any overdue account. There will be a \$35.00 fee for any returned checks. We reserve the right to charge our typical adjustment fee for missed appointments without prior notification.

PLEASE CHECK ONE:

I HAVE HEALTH INSURANCE THAT WILL CONTRIBUTE TO MY CARE

(PLEASE GIVE INSURANCE CARD AND PICTURE ID TO FRONT DESK. IF INSURANCE IS UNDER A SPOUSE/PARENT, PLEASE LIST THEIR DATE OF BIRTH HERE _____ FOR VERIFICATION PURPOSES.)

Our recommendations for care are individually designed to help each practice member reach his or her full genetic health potential. They are not based on what your insurance company will or will not pay. Remember, your agreement is between you and your insurance company, not your insurance company and this office. By signing this agreement, you authorize Fountain of Life to accept assignment on your behalf for services rendered in this office. This office will not enter into any disputes with your insurance company beyond providing with the minimal paperwork necessary to process the typical claim. Patients are ultimately responsible for all charges in this office, including any services which exceed insurance policy limitations for specific number of visits or dollar amounts. Any insurance claim that hasn't been paid within 60 days of filing becomes the patient's responsibility. If you are like most of our practice members and choose to participate in an Active Life Plan, we may file your insurance for you and allow you to make budget installments toward the estimated uncovered charges. We will discuss these options with you at your Report of Findings during your next visit. Your signature below gives us permission to release your health information to your insurance company, allows them to make any contributions to your care directly to our office, and gives us limited power of attorney to endorse any check made out to you for services rendered by our office to you or on your behalf.

I HAVE NO INSURANCE COVERAGE, OR I PREFER NOT TO FILE

Many of our families have no insurance coverage for their chiropractic care. To help make chiropractic care more affordable when there is no insurance to contribute toward your care, several affordable investment plans are available to choose from.

FIRST VISIT SERVICES ARE EXPECTED TO BE PAID IN FULL TODAY UNLESS OTHER ARRANGEMENT
HAVE ALREADY BEEN MADE.

METHOD TO TAKE CARE OF TODAY'S CHARGES (PLEASE CHECK ONE): CASH CHECK CREDIT CARD

IF YOU HAVE ANY QUESTIONS CONCERNING OUR FINANCIAL OR INSURANCE POLICY, PLEASE DO NOT HESITATE TO
SPEAK WITH US.

I have read, understand, and agree to this financial policy. I authorize the staff of Blumhardt Family Chiropractic, PC dba Fountain of Life ChiroStudio to examine me and render chiropractic care as deemed appropriate.

Signature

Date