Welcome to McGuire Chiropractic Health Center!

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions.

We look forward to serving you.

Name_____ Age_____

Address_____

City_____ State_____ Zip_____

Cell #_____ SS #_____

Email_____

Birthdate_____ M/F____ Marital Status_____

Type of work/employer_____

Do you have children?_____ Ages_____

Do you notice poor postural habits in your kids?_____

How were you referred to this office?_____

Emergency contact_____

Emergency contact's phone #_____

Reason for today's visit_____

_____

When did this condition begin?_____

Describe_____

_____

What activities aggravate your symptoms?_____

_____

Does anything relieve your symptoms?_____

_____

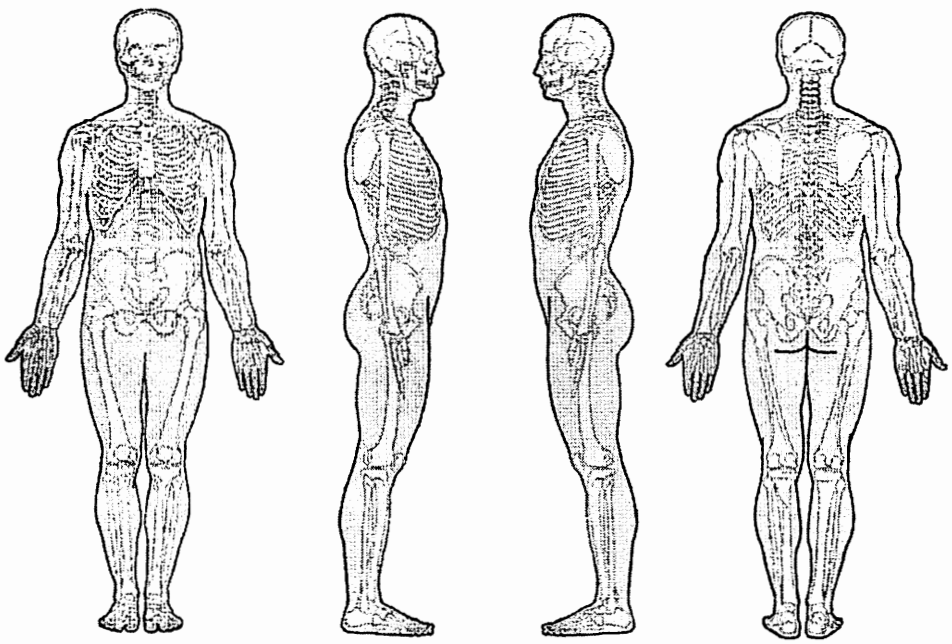
Have you experienced this condition before?_____

Who treated you for this condition?_____

How did you respond?_____

_____

Please, mark your area(s) of pain on the following figures and rate the average intensity on the scale.



Worst pain (10)

Least pain (0)

Have you ever seen a Chiropractor before?_____ Who?_____ When?_____

Reason for visits_____ How did you respond?_____

Are you aware of any of your poor postural habits?_____

Did you know poor posture determines your health (y/n)_____ The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health.

Do you exercise?_____ How often?_____ Do you smoke?_____ How often?_____

Do you drink alcohol?_____ How often?_____ Do you drink coffee?_____ How often?_____

Do you take any supplements (vitamins, minerals, herbs)?_____

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called **subluxations**. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted **posture**. Postural distortions have many serious and adverse effects on your overall health.

CERVICAL SPINE (NECK):

Postural distortion from **subluxations**, causing **forward head syndrome**, in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience...?

- ☐ Neck pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent Colds/Flus
- ☐ Low energy/Fatigue
- ☐ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

Postural distortion from **subluxations**, resulting from **forward head syndrome**, in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- ☐ Heart palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/Angina
- ☐ Recurrent lung infections/bronchitis
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

THORACIC SPINE (MID BACK):

Postural distortion from **subluxations**, resulting from **forward head syndrome**, in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Indigestion/heartburn
- ☐ Hypoglycemia
- ☐ Tired/irritable after eating or when you haven't eaten for a while
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/gastritis

LUMBAR SPINE (LOW BACK):

Postural distortion from **subluxations**, resulting from **forward head syndrome**, in the low back will weaken the nerves into your legs/feet and pelvic organs, and affect these parts of your body. Do you experience...?

- ☐ Low back pain
- ☐ Pain into your hips/legs/feet
- ☐ Numbness/Tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Constipation/diarrhea
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction

Please list any health conditions not mentioned. _____

_____

Please list any medications/surgeries. _____

_____

Please list any traumas.(falls, car accidents, etc.)_____

_____

All of the information provided above is accurate and true to the best of my knowledge.

_____ _____

Patient Signature Date

PAYMENT/INSURANCE AGREEMENT

In consideration of your undertaking and care of me, I agree to the following:

****YOU ARE RESPONSIBLE FOR COMMUNTICATION WITH YOUR INSURANCE COMPANY AND UNDERSTANDING YOUR HEALTH INSURANCE****

If for any reason my account is delinquent for over 30 days, I hereby authorize McGuire Chiropractic to collect the full amount from my credit card account listed below, along with a 3% office fee (i.e.: $55 balance will result in a charge of $56.65 total charge to my credit card).

OR

In the event my insurance company forwards payment for services rendered at your office directly to me (specifically Blue Cross and Blue Shield Members) I will be responsible to render such payments to McGuire Chiropractic, along with the Explanation of Benefits that was provided to me, within 10 days. Even if the Explanation of Benefits is a "0" balance/payment I will either mail/bring in or send you a picture of that EOB as soon as I receive it, to avoid being charged for the office visit.

If for any reason I do not issue McGuire Chiropractic the original payment or a personal payment within 10 days, I hereby acknowledge my account will be in a delinquent status.

If I choose not to provide my credit card information to avoid such matters, I hereby acknowledge that my information will be forwarded to an outsourced collection agency, which will affect my credit. I understand that McGuire Chiropractic will take aforementioned action if I do not contact them to arrange a payment within 30 days of my delinquent status. If I provide my credit card information to McGuire Chiropractic and the payment is declined for any reason I understand I will have five business days to forward a new form of payment to your office, if not, I am aware that you will send me to collections.

OR

If I choose not to provide my credit card information to avoid such matters, I hereby acknowledge that I WILL BE CONSIDERED A CASH PATIENT and I understand that I can submit to my insurance company directly.

Responsible party for insurance payments:

Name:_____ Relationship:_____

Address_____

Credit Card: MasterCard Visa American Express HSA Discover

Card Number: _____ Security Code:_____

Expiration Date:_____

Patient signature:_____ Date: _____

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES

Our office uses sign-in sheets, travel cards, and provides care in an “open-door” adjusting environment. Adjustments are done in an open adjusting area as a result patients are in sight of each other and some on going routine details of care may be overheard by other patients and/or staff. This environment is used for on going care and is not the environment for taking patients histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity.

In addition, your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient's Signature: _____ Date: _____

Privacy Policy Received

Patient's Signature Date: _____ Date: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by McGuire Chiropractic, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of McGuire Chiropractic. I understand that Dr. McGuire may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above-stated purposes.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. McGuire Chiropractic is not required to agree to the restrictions that I may request however, if McGuire Chiropractic agrees to a restriction that I request, the restriction is binding to McGuire Chiropractic and Dr. McGuire.

I understand I have a right to review McGuire Chiropractic's Notice of Privacy Practices (which has been provided to me) prior to signing this document. The Notice of Privacy Practices describes the type 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 McGuire Chiropractic. The Notice of Privacy Practices for McGuire Chiropractic is also provided on request at the front desk of this practice. Notice of Privacy Practices also describes my rights and McGuire Chiropractic's duties with respect to my protected health information.

McGuire Chiropractic has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling McGuire Chiropractic's office and request a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have a right to revoke this consent in writing, at any time, except to the extent that McGuire Chiropractic or Dr. McGuire has taken reliance on this consent.

Patient/Guardian Signature: _____ Date: _____

REMINDER OPTIONS

McGuire CHC is an easy-going stress free zone. To make things as convenient as possible for our patients, we offer two options for appointment reminders. Please check which option you prefer.

☐ Please call me to remind me of my appointments

☐ Please text me to remind me of my appointments

_____

Phone Number

If you should miss an appointment, we will use your preferred choice of contact to reschedule the appointment.

Most smartphone plans have unlimited texting. If your plan does not have this feature, standard text messaging rates will apply.

Patient Photo and Testimonial Release Information

I, _____, authorize Dr. Tom McGuire, D.C. to use my photo for advertisement and/or public review. This is including, but not limited to newspaper, patient newsletters, websites, internet, Facebook, YouTube, Instagram, social media, and/or mailings, etc.

My statements are given freely and without any coercion or incentive. I agree to allow editing as needed for adaptation for different Medias.

I understand that I may revoke my permission to use my personal health information at anytime and will notify Dr. Tom McGuire, D.C. in writing.

Name (Print):_____

Signature: _____ Date:_____

Witness: _____ Date:_____