

NEW PATIENT FORM
"Your Lifetime Family Wellness Center!"

Date _____

Name: _____ Address _____
City: _____ State: _____ Zip/Postal Code: _____
Home Phone:(_____) _____ Birth Date: _____ Age _____ Sex: M F
Cell Phone:(_____) _____ Work Phone:(_____) _____
Email: _____ Social Security Number _____ - _____ - _____
Choose One: Married Single Widowed Divorced
Business Employer: _____ Type of Work: _____
Name of Spouse _____ Spouse's Employer _____
Referred To This Office By _____
Names and Ages of Children _____
Name and Number of Emergency Contact: _____
Relationship _____
Who Is Responsible For Your Bill, You and Spouse Auto Insurance Medicare Workers' Comp.
 Personal Health Insurance (Name) _____ Health Card # _____
Insured Person's Name _____ Date of Birth _____



CURRENT HEALTH CONDITION

Unwanted Health Condition(s): _____
Other Doctors Seen For This Condition Yes No` Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is the Condition Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made a Report to Your Employer : Yes No
Medications You Currently Take: Pain Killers/Muscle Relaxers Nerve Pills Blood Pressure Medicine
 Insulin Other: _____
Do You Wear a Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____



PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Gall Bladder Hernia Cardiac Surgery Disc
Surgery Back/Neck Spinal Surgery Broken Bones Other _____

BRACKNEY CHIROPRACTIC HEALTH CENTERS PLLC

8524 Canton Center Canton, MI 48187

(734) 455-4444

Name _____ Date _____

Major Accidents or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care None Doctor's Name and Approximate Date of Last Visit _____

CHECK OFF ANY OF THE FOLLOWING DISEASES YOU HAVE HAD/HAVE:

- Arthritis
- Epilepsy
- Cancer
- Mental Disorders
- Diabetes
- Anemia
- Heart Disease
- Other _____

DAILY INTAKE:

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you ever tested positive for HIV Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Neck Pain
- Pain Across Top of Shoulders
- Pain Between Shoulders
- Low Back Pain
- Joint Pain
- Arm/Leg Pain
- Joint Stiffness
- Difficulty Walking
- General Stiffness
- Headaches

GENITO-URINARY

- Bladder Problems
- Painful/Frequent Urination
- Kidney Stones/ Infections

C-R-V

- Stroke
- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Ankle Swelling

NERVOUS SYSTEM

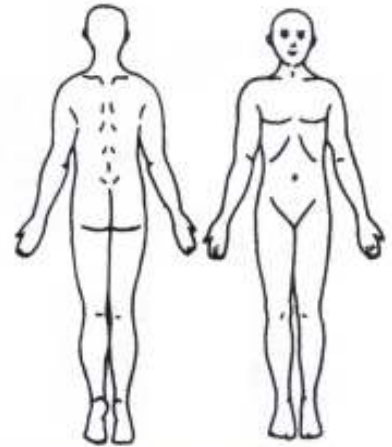
- Stress
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- ADD/ADHD
- Easily Confused
- Depression
- Seizures/Convulsions
- Tingling Extremities
- Fatigue
- Loss of Sleep
- Fever

EENT

- Allergies
- Sore Throat
- Vision Problems
- Ear Aches
- Stuffed Nose
- Hearing Difficulty

MALE/FEMALE

- Menstrual Cramps
- Prostrate/Sexual Dysfunction
- Menstrual Irregularity
- Breast Pain/Lumps
- Other _____



Please outline on the diagram the area of your discomfort

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GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea/ Constipation
- Hemorrhoids
- Heart Burn
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas Bloating After Meals

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited on my account receipt. However, I clearly understand and agree that all fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to discuss my case with me and perform necessary examinations/tests. It is understood and agreed the amount paid the Doctor for x-rays is for, the actual taking of, examination of and interpretation of, the X-rays. The X-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred in this office.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

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Name _____ Date _____

SPINAL HEALTH QUESTIONNAIRE

1. I have pain None at all
 Occasionally
 Intermittently
 Continuously
2. My pain is Mild
 Moderate
 Severe
3. I can sit Not at all
 Only with pain
 Only for a short period of time before pain begins
 For a moderate amount of time before pain begins
 As long as I wish
4. I can drive Not at all
 Only with pain
 Only for a short period of time before pain begins.
 For a moderate period of time before pain begins.
 As long as I wish
5. I can stand Not at all
 Only with pain
 Only for a short period of time before pain begins.
 For a moderate period of time before pain begins.
 As long as I wish
6. I can bend Not at all
 Only with pain
 Only for a short period of time before pain begins.
 For a moderate period of time before pain begins.
 As long as I wish
7. I can lift Not at all
 Only light weights (1-10)
 Moderate weights (11-30)
 Heavy weights (31 or more)
8. I can walk Not at all
 Only with pain
 Only for a short period of time before pain begins.
 For a moderate amount of time before pain begins.
9. My sleep is Undisturbed
 Lightly disturbed (1-2 hrs sleepless)
 Moderately disturbed (2-4 hrs sleepless)
 Severely disturbed (4 or more hrs sleepless)
10. I am Not at all
currently Light duties
working Regular duties
11. I am able to Not at all
Perform my Partially
Job duties Completely
12. I am able to Not at all
Perform household Partially
Duties Completely
13. I need attendant Yes
Care No

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Relationship to patient

Patient or legal Guardian Signature

Date

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Brackney Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive your appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide our office with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

This office may use name boards to acknowledge patients for referrals, birthdays, or other special promotions in open areas where others may view your name only. No other protected health information would be used. You may occasionally receive a nominal gift from this office. Periodically, you may receive newsletters from this practice that highlight practice activities and information on products and services that will benefit your health. This office may occasionally contact you via email regarding appointment times, care information, or general communication both in active care and post care.

You will have the opportunity to talk to your doctor and staff in private. However, this practice provides treatment in an open area. This means that statements made by you or practice employees may be overheard by others. In addition, you will sometimes receive treatment within sight of other patients. If you have comments you wish to make privately when you are brought to the treatment area or during treatment, please inform the doctor or staff and we will accommodate your request. This open environment is used for ongoing care and is NOT the environment used for taking patient histories, performing evaluations or presenting reports of findings. These procedures are completed in a private, confidential setting.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

- If we are providing health care services to you based in the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intended for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than at your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health care information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy policies with respect to your health information. Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy policy will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you may direct your complaint to the Secretary of Health and Human service, or you may notify our staff of any complaint. We will not retaliate against you for filing a complaint. Direct any complaints or requests for further information about our privacy policies and practices to Dr. Michael Brackney.

This notice is effective as of February 8, 2010.