9865 E. 116th Street, Suite 150
Fishers, IN 46037
(317) 808-5675

Patient Name _____
Date _____
Chart # _____

CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone _____

Age _____ Birth Date _____ Marital Status ☐ Married ☐ Single ☐ Widowed Divorced No. of Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Email Address _____ Do we have your permission to send you emails? YES NO

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Office Phone_____

Patient's Nearest Relative _____ Relative's Home Phone _____

How did you hear about our office, did someone refer you in? _____

Emergency Contact _____ Phone_____

Date of Last Physical Examination _____ Medical Doctor's Name _____

Mission Statement: To assist those in their quest for optimal health and living a MAXimized LIFEstyle!

At **MaxLife**, our objective is to match up our care with your goals. Our **first** priority is to improve your overall quality of life. Our **second** priority is to address the underlying issues that are causing you complications with your overall health. Our **third** priority is to address what cause(s) these issues to begin with. **Lastly**, what can be done to prevent these issues from causing overall health complications in the future. You will have an opportunity to pursue the type of care that best suits your needs. We will present to you optimal recommendations and other options that may be more suitable considering your circumstances as well.

We recognize there are three categories of stress; chemical, physical and mental stresses that can afflict the body. We will educate you on what causes the body to break down and what can be done to increase the likelihood of preventing the same type(s) of things happening in the future.

What are the reason(s) for you presenting to our office today (if you're coming in for performance-based care and have no issues state that as well):

Problem(s)	Severity (0-10, 10-worst)	Issue started?	Had this before, when?	Due to injury?	Issue: constant (C) or intermittent (I)?
1.					
2.					
3.					
4.					

Is the pain sharp or dull?_____ Does the pain travel/radiate anywhere?_____

_____

Are the problem(s): getting better, worse, same?_____. What makes it worse?_____

What makes it feel better?_____What hasn't helped?_____

Family history of any of the problems you're having, please explain?_____

How are the issues affecting your life (work, hobbies, physical activity, attitude, etc.)?_____

_____

Have you made any changes to your lifestyle recently that have impacted your life in a beneficial way?_____

_____

Other **Doctors** seen for your issues: Chiropractor (DC), Medical Doctor (MD), etc…

Doctor:_____ Date:_____ Diagnosis:_____ Action taken:_____

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Doctor:_____ Date:_____ Diagnosis:_____ Action taken:_____

Are you on any meds (prescription and non-prescription), if so, please list:_____

_____

Any surgeries (please list along with date and Dr.):_____

_____

Any **major or minor** injuries that may or may not be related to your current condition, please list if you were **hospitalized** as well; please include **date**:

Type:_____ Taken to hospital (Y/N)_____ Date:_____

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Please list if you've had **X-rays**:

Area of body:_____ Date:_____ Location:_____

Area of body:_____ Date:_____ Location:_____

Area of body:_____ Date:_____ Location:_____

Foot/Hip/Spine Stabilizers:

Do you wear orthotics or heel lifts (Y/N?):_____ If NO, have you ever contemplated them or had them recommended to you (Y/N?):_____

Self-assessment tool (what stresses most affect you on a daily basis?):

Mental ("personal and professional life": job, home life, relationships, self-esteem, finances, etc.):_____

_____

Physical ("activities you do or don't do": exercise, sedentary lifestyle, hobbies, sports, posture, falls, accidents):_____

_____

Chemical ("what you put into your body"; poor diet, smoke, water intake deficient, alcohol, drugs, etc.):_____

_____

What health issues does your family deal with:

Children:_____

Spouse:_____

Mother:_____

Father:_____

Brother(s):_____

Sister(s):_____

Other relatives:_____

Health Enhancements:

Do you presently (please circle number, if applies)?: 1. Buy bottled water. 2. Go to fitness center. 3. Take supplements. 4. Buy organic. 5. Play on sports team(s).

6. Have family physical activity time. 7. Read self-help, health-oriented material. 8. Other(s):_____

Do you have an interest in determining if there's a need for dietary changes to be made and if so, what can be done about it (Y/N)?_____

If stretches/exercises would be beneficial, do you have an interest in special time being set aside to have these things discussed (Y/N)?_____

If there's a need for help with mental challenges you've been dealing with, is there an interest in discussing these matters to see what potential solution(s) there are (Y/N)?_____

Health Still Shot:

On a scale of 0-100, taking into account your overall health condition, where are you at right now; 100=highest):_____ Where would you like to be?_____

Have You Ever Suffered From:

	YES	NO		YES	NO		YES	NO
1. Dizziness	☐	☐	8. Asthma	☐	☐	15. Female: Is there a chance you could be pregnant?		
2. Backaches	☐	☐	9. Neuritis	☐	☐			
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐			
4. Diabetes	☐	☐	11. Nervousness	☐	☐			
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐			
6. Arthritis	☐	☐	13. Anemia	☐	☐			
7. Headaches	☐	☐	14. Cancer	☐	☐			

Please check any symptoms below you are experiencing or have experienced in the past:

☐ Headache	☐ Dizziness	☐ Eyes Sensitive to Light	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Cold Feet
☐ Neck Stiffness	☐ Pins and Needles in Arms	☐ Ringing in Ears	☐ Cold Hands
☐ Problems Sleeping	☐ Pins and Needles in Legs	☐ Flushed Face	☐ Upset Stomach
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ Other _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT!

Will you be paying today by ☐ Cash ☐ Check ☐ Credit Card

Name of Person Responsible for Payment _____

Are you Insured ☐ Yes ☐ NO Company _____ Policy #_____

I authorize payment of medical benefits to MAXLIFE CHIROPRACTIC for the services described on the insurance form. This authorization is to apply to all dates of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. I understand that MaxLife Chiropractic may call to verify my insurance benefits as a courtesy, but I should also contact my insurance company to better understand my coverage.

Patient's Signature _____ Date_____

Guardian or Spouse's Signature _____ Date _____

Information Taken By _____ Date_____

MAXLIFE CHIROPRACTIC
9865 E. 116th Street, Suite 150
Fishers, IN 46037
(317) 808-5675

Chart # _____
Patient Name _____
Date_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent for stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy office has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. In the interest of the patient's health and progression through care, there may be consultation between staff and healthcare providers regarding their PHI.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
9. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
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11. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
12. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
13. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy office has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
14. In the interest of the patient's health and progression through care, there may be consultation between staff and healthcare providers regarding their PHI.
15. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
16. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

_____

Patient Name Patient Signature Date

MAXLIFE CHIROPRACTIC
9865 E. 116th Street, Suite 150
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Patient Name _____
Date _____

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, ultrasound, weighted traction, or exercises may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could include fractures of bones, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risk Occurring: The risks of complications due to chiropractic treatment have been described as “rare”. About as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other Treatment Options that could be Considered: (may include the following)

- Over the counter analgesics: The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases
- Medical Care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent diseases in a significant number of cases
- Surgery in conjunction with medical adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases

Risk of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that the delays of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual Risks: I have had any unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Is it okay to talk to your spouse regarding your health? □Yes □No

If you have anyone you would like to give us permission to discuss your health with, please write their name(s) here:

_____

Patient Name	Patient Signature	Date
Witness Name	Witness Signature	Date

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU WERE INVOLVED IN AN ACCIDENT

Date of Accident _____ Hour _____ AM ___ PM ____ Location_____

How did the Accident Occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

If on-the-job injury, how did it happen? (Please be specific)

_____

_____

What is your Job Title/Duties? _____

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did you tell them you were coming to our office? ☐ YES ☐ NO

If auto accident, were you? ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you stuck from? ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved? ☐ YES ☐ NO ☐ Undetermined

Did the other car(s) strike yours? ☐ YES ☐ NO ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ YES ☐ NO

Were traffic citations issued to the other driver(s)? ☐ YES ☐ NO

Please list the extent of your known injuries: _____

_____

Did you require post-accident hospitalization? ☐ YES ☐ NO

Please check the symptoms below that you noticed since your accident

☐ Headache	☐ Dizziness	☐ Eyes Sensitive to Light	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Cold Feet
☐ Neck Stiffness	☐ Pins and Needles in Arms	☐ Ringing in Ears	☐ Cold Hands
☐ Problems Sleeping	☐ Pins and Needles in Legs	☐ Flushed Face	☐ Upset Stomach
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ Other _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	

Have you missed any days of work? ☐ YES ☐ NO Dates _____

Insurance Companies Involved (auto accidents only)

Your Insurance Company _____

Insurance Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney that has advised you in this case? ☐ YES ☐ NO

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date_____

Information Taken By _____ Date_____