WELCOME TO STOVER CHIROPRACTIC, P.C.

Congratulations on your decision to join the millions of people who are enhancing their lives through regular chiropractic care. We, at Stover Chiropractic, P.C., welcome you and will strive to provide you and your family with the very best chiropractic care possible.

PATIENT IDENTIFICATION

Name: ____Date: ____________________________

Address: _______________________________________City: _____________________ State & Zip: ____________

Phone: (H) ________________________ (W) ___________________________ (C) __________________________

Email: ____ Marital Status: S M D W

DOB: ____________________ Age: _____________ Social Security #: ____________________________________

Occupation ____________________________Name of Employer ____

Emergency Contact: __________________________ Phone: ______________ Relationship: ___________________

Whom may we thank for referring you to our office? ____

Hobbies/Sports/Leisure Activities you enjoy: ____

RESPONSIBLE PARTY

Name of person responsible for this account: ____
Relationship to patient: ____ Phone #: _______________________
Address: ________________________City: __________________________ State and Zip: ___________________
Name of employer: _______________________________________ Work #: ________________________________

INSURANCE INFORMATION, ASSIGNMENT AND RELEASE

This office will verify and file most insurance for you; however, we ask that today's visit be paid for in full regardless of that coverage. If it is determined that all or part of today's visit is a covered expense, a refund and/or credit will be provided to you. Please provide the Chiropractic Assistant with your card so that we can verify coverage.

I certify that I and/or my dependant(s), have insurance coverage with _______________________________________ and assign directly to Dr. Stover and Stover Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature below on all insurance submissions.

The above-named Doctor and his representatives may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient, Parent, Guardian ____ Date________________

9129 Dickey Drive Mechanicsville, VA 23116

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

What type of care are you looking for? (check all that apply)
____**Relief /Patch Care** - Relief from pain and/or symptoms.
____**Corrective Care** – Identify the cause(s) of my concern(s) and correct it/them.
____**Wellness Care** – Once correction has occurred, continued optimal health and wellness
HEALTH CONCERNS AND/OR SYMPTOMS: Briefly describe your concerns in order of priority:
1.____
2.____
3.____

Circle the appropriate number of your concerns with 1 being "No pain" through 10 being "Unbearable pain"

 # 1: 1 2 3 4 5 6 7 8 9 10 **# 2:** 1 2 3 4 5 6 7 8 9 10 **#3:** 1 2 3 4 5 6 7 8 9 10

When did you first notice these concerns? 1.________________2.________________3.________________
How did this/these concerns occur? 1.__________________2.__________________3.__________________
Have you had this/these concerns before? If yes, how long ago? 1.___________2.___________3.___________

With reference to your #1 concern:
1. If you are experiencing discomfort or pain, is it...
   ___ Sharp ___ Dull ___ Burning ___ Comes and goes ___ Travels ___ Constant___ Other ___________
2. Since your concern started, it is... ___ About the same ___ Getting better ___ Getting worse
3. What makes it worse? ______________________________Better? ______________________________
4. It interferes with: ___ Work ___ Sleep ___ Walking ___ Sitting ___ Hobbies ___ Leisure
5. Other Doctors seen for this concern and results (please list names):
   Doctor of Chiropractic_____________________________ M.D._______________________________
   Physical Therapist_________________________________ Other______________________________
6. Please put an "X" by all symptoms you are currently experiencing and check ("√") all symptoms you have had, even if they do not seem related to your current concerns.

__ Headaches/Migraines
__ Pins & needles in arms
__Dizziness
__Numbness in fingers
__ Fatigue
__Sleeping problems
__Diarrhea
__Cold Sweats
__Mood swings
__Pins & needles in legs
__ Loss of smell
__ Buzzing/ringing in ears
__ Numbness in toes
__ Depression
__ Stiff neck
__ Constipation
__ Lights bother eyes
__ Menstrual pain/irregularity
__ Fainting
__ Back pain
__Nervousness
__ Loss of taste
__ Irritability
__ Cold hands
__ Fever
__ Asthma/Allergies
__ Shoulder pain
__ Neck pain
__Loss of balance
__ Sinus
__ Stomach problems
__ Sinus concerns
__ Cold Feet
__ Hot flashes
__ Heartburn
__ Cancer

7. Do you feel older than you feel you should for your current age? Yes ___ How much older? ____ years No ___

8. What do you hope to enjoy more when you regain your health? ______________________________

The information I provided on this form is accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to receive appropriate care.

Signature ____ Date __________________

HEALTH HISTORY

ALLERGIES: Please list all allergies/sensitivities

____

____

MEDICATIONS: Please list all medications (Prescription and/or OTC) you are currently taking and when you started

	Medication Name		Medication Name
Antacids		Blood Pressure	
Antibiotics		Cholesterol	
Antidepressants		Pain Medications	
Anti-Diabetics		Hormone Replacements	
Anti-Inflammatories		Other	

List supplements you are taking or have taken: ____

____

List all surgical procedures you have had and when:____

____

List all Accidents (auto, slips and falls, work related, etc) and when: ___________________________

____

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress	☐	☐	☐	☐

	5+/wk	**3-5x/wk**	**1-3x/wk**	**None**
Exercise	☐	☐	☐	☐
	8+ hrs	**7-8 hrs**	**6-7 hrs**	**<6hrs**
Sleep	☐	☐	☐	☐
Water	**64+ oz**	**32-64 oz**	**16-32 oz**	**<8oz**
	☐	☐	☐	☐

WORK ACTIVITY: ☐Heavy Labor ☐Light Labor ☐Mostly Sitting ☐Mostly Standing ☐Driving/Travel

FAMILY HISTORY: Identify any conditions that you or your family members have now or have had in the past:
(**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)

_____Alcoholism
_____Anemia
_____Cancer
_____Cold Sores
_____Deep vein thrombosis
_____Detached Retina
_____Diabetes
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart Disease
_____HIV/Aids
_____Miscarriage
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic Fever
_____Stroke
_____Tumors
_____Ulcers
_____Other: _______________
____
____

The information I provided on this form is accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to receive appropriate care.

Signature ____ Date ____

Stover Chiropractic, P.C.

9129 Dickey Drive Mechanicsville, VA 23116 804-559-1100

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both that objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Health**: A state of optimal, physical, mental and social well-being, not merely the absence of disease and 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 ability to express its maximum health potential.**

We do not offer to diagnose or treat any condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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 the 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 (vertebral subluxation) to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, ____, have read and fully understand the above statements.
Print Name

Signature ____ Date _______________________

CONSENT TO EVALUATE A MINOR CHILD

I, ______________________________, BEING THE PARENT OR LEGAL GUARDIAN OF __________________, have read and

fully understand the above terms of acceptance and hereby grant permission for my child to be evaluated for subluxation.

PREGNANCY RELEASE

By my signature I certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my

permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: ______________________________

Signature ____ Date _____________________

Stover Chiropractic, P.C.
9129 Dickey Drive
Mechanicsville, Virginia 23116
(804) 559-1100 fax 746-0500

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has been offered a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I give specific permission to Stover Chiropractic, P.C., its employees and agents to:

use my address, phone numbers, email and/or text message to contact me with appointment reminders, missed visit appointment notification, birthday cards, holiday related cards, newsletters and/or information regarding treatment alternatives and/or other health related information,

contact me by phone, email or text and leave a phone, email or text message regarding appointments, changes in schedule, etc. if you are unavailable,

provide care in an environment where other patients are also receiving care. I am aware that other persons in the office may overhear some of my protected health information during the course of care and that should I need to speak with the Doctor at any time in private, the doctor will provide a room for these conversations,

use "travel cards" (notes regarding my care) containing private health information during the course of my chiropractic care,

and to use a sign in sheet that may be seen by others as a record of my visit to the office,

By signing this form you are giving Stover Chiropractic, P.C. permission to use and disclose your protected health information in accordance with the directives listed above.

Signature ____ Date ___________________

If patient is a minor or under a guardianship order as defined by State law: _________________________________

Signature of Parent/Guardian (circle one)

Effective September 23, 2013 and until further notice

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