ABOUT THE PATIENT

614 CHIROPRACTIC
HEALTH • INJURY CARE

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Marital Status: _____Gender ❑ M ❑ F Significant Other's Name _____

Have you been to a chiropractor before? ❑ No ❑ Yes When was your last Chiropractic Appointment? _____

Your Employer _____ Type of Work _____

E-Mail Address _____ Who Referred you to us?_____

Emergency Contact _____ Ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- Understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

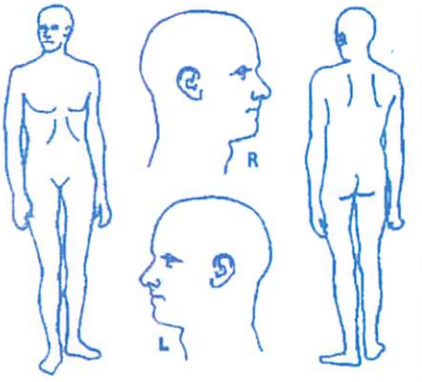
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No
How far along? _____
Due Date: _____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Paying for your care is easy here!

614 CHIROPRACTIC
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Initial which one is you:

❑ **No Insurance**:

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like Lasik, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial_____

❑ **Health Insurance:**

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial_____

❑ **Auto Injury**

- Most Auto related injuries are covered 100% in Ohio for patients not at fault. You can get the care you need and it normally costs nothing. Great for you!
- All we need is your claim number and insurance information.

Initial_____

❑ **Medicare**

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial_____

You have made a great decision to get care here!

Our goal is to be your family chiropractor for life!

Informed Consent for Care at 614 Chiropractic

Dear Patient (or Parent/Guardian of the Patient Named Below), We are committed to providing you with safe, effective, and natural chiropractic care to support your health and wellness. Please read this form carefully to understand what to expect from your care, its benefits, and any rare risks. If you have any questions, please ask us—we're here to help!

What is Chiropractic Care? Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints. These adjustments aim to improve your body's alignment, movement, and overall function, helping you feel your best naturally.

What to Expect During Your Care:

· **Initial Evaluation**: We'll start with a thorough health history and physical exam, which may include checking your posture, movement, muscle strength, and other tests to understand your needs. In some cases, X-rays may be recommended to get a clearer picture of your health.

· **Personalized Care Plan**: Based on your evaluation, we'll create a tailored plan that may include adjustments, soft tissue therapies, exercises, nutritional advice, or home care recommendations. If needed, we may refer you to other healthcare professionals for additional support.

Benefits of Chiropractic Care: Chiropractic care helps many patients feel better and live healthier lives. Potential benefits include:

· Reduced pain or discomfort in your back, neck, or joints.

· Improved mobility, flexibility, and posture.

· Enhanced overall wellness, energy, and physical performance.

Every patient is unique, so results may vary. We'll work closely with you to support your health goals.

Understanding Rare Risks

Chiropractic care is very safe, but like any healthcare approach, there are rare risks. We take every precaution to ensure your safety, including a thorough evaluation to identify any concerns. Possible risks, though very uncommon, may include:

· Temporary soreness or discomfort after adjustments (similar to how you might feel after exercise).

· In very rare cases, minor muscle or ligament strain.

· Extremely rare risks, such as irritation to a disc or nerve, or, in exceptional cases involving neck adjustments, a very low risk of stroke (estimated at less than 1 in 1 million, much lower than risks from everyday activities like driving).

We use your health history, exam, and X-rays (if needed) to minimize these risks. Please share any health conditions or concerns with us, as this helps us tailor your care to keep you safe.

What Happens if You Choose Not to Pursue Chiropractic Care? If you decide not to proceed with chiropractic care, you may continue to experience discomfort, limited mobility, or other symptoms. Over time, untreated issues could worsen, potentially leading to longer recovery times or more complex treatments. We're here to discuss all your options to help you make the best choice for your health.

Other Care Options: Instead of or in addition to chiropractic care, you might consider:

· Rest or over-the-counter pain relievers.

· Physical therapy, medical care, or prescription medications.

· In some cases, advanced options like injections or surgery.

We'll help you understand these options and how they compare to chiropractic care.

Your Rights and Responsibilities:

· **Your Right to Choose**: You can stop or modify your care plan at any time. Just let us know what you're comfortable with.

· **Your Responsibility**: Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.

Photos and Text Reminders: By signing this form, you also agree to the following (please check the boxes to opt in or out):

· **Photos for Social Media**: I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time.

· **Text Appointment Reminders**: I agree to receive text reminders for my appointments to help me stay on track.

Our Commitment to You

We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

Your Consent:

By signing below, I confirm that:

· I have read and understood this form, and my questions have been answered to my satisfaction.

· I understand the benefits, rare risks, and alternatives to chiropractic care.

· I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.

· I understand I can stop or change my care plan at any time.

· I agree to the checked options above regarding photos and text reminders.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

Date: _____