

**NORTHPOINTChiropractic & Family Wellness Center**

**PLEASE TELL US ABOUT YOURSELF**

Name (last) (first) (mi) .

Home Address (street) .

.

(city) (state) (zip) .

Home Phone ( ) Mobile ( ) .

Birthdate / / Age .Email Address .

Employer Occupation

Work Phone ( ) Ext. .

Male / Female (please circle) Single / Married / Partnered / Divorced / Widowed / Separated

Spouse/Partner’s Name (last) (first) .

Employer Work Phone .

Number of Children Names and Ages .

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Emergency Contact Phone .

Whom may we thank for referring you to NorthPoint Chiropractic? .

Reason for consulting NPC? .

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.How has this affected your life (family, occupation, recreation, concern for future health, etc)? .

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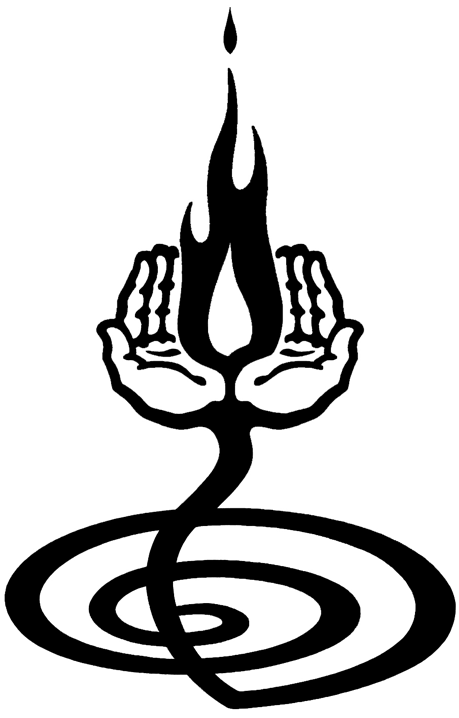
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Is there anything else you would like us to know? .

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NORTHPOINTChiropractic & Family Wellness Center

**Informed Consent**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, Craniosacral therapy and subtle energy rebalancing on me (or on the person named below for whom I am legally responsible) by Eric Rubin, DC, CMT or any doctors of chiropractic working or associated with or covering at NorthPoint Chiropractic and Family Wellness Center.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, sprains, fractures, disc injury, stroke and dislocations. I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust joints and release muscles, which may cause an audible “click” or “pop” during the procedure.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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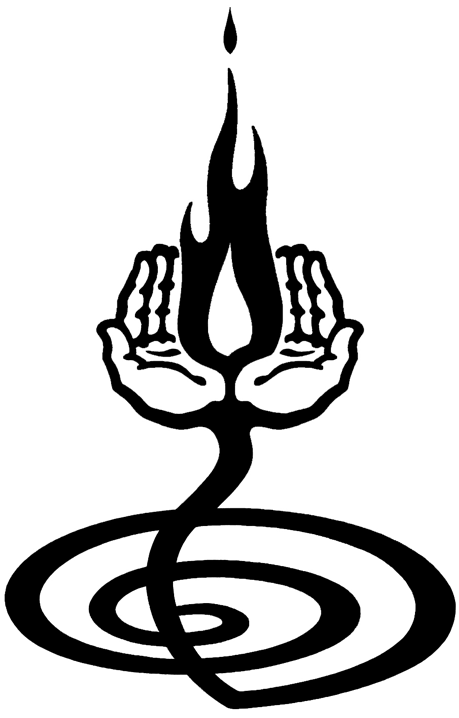
Name (Printed) Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

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Witness to Patients’ Signature



NORTHPOINTChiropractic & Family Wellness Center

**PERSONAL HEALTH HISTORY (Confidential)**

Name Date .

The body is designed to be healthy. Throughout life, events and experiences can occur which may have negatively affected your body’s expression of health. The following questions will help uncover possible types of input that may impede your body’s ability to fully express your health potential. The science of Chiropractic revolves around the detection and release of nerve interference and tension patterns stored in the spine and throughout the body called subluxations. Subluxations are caused by physical, chemical, and emotional stresses to which the body cannot adapt. In order to understand the current state of your health, please be as thorough as possible with the following information.

**Reason for seeking chiropractic care:**

To experience a new level of health and healing To relieve my pain .

To be more connected to my body Not sure Other reason .

What is your level of commitment to yourself, your health, your wellbeing? High Medium Low .

Previous Chiropractic: YES/NO If yes, date of last adjustment Name of chiropractor .

Reason for ending care: .

Are you currently receiving medical attention and if so, for what? .

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Please list any medications you are currently taking (prescription and non-prescription): .

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Please briefly describe your daily routine, including meals and snacks: .

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What are your daily exercise habits? .

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What are your current play/relaxation activities? .

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How would you rate your current health? Poor Fair Average Good Excellent

How would you describe your family’s health? Poor Fair Average Good Excellent\

Are you healthier now than you were 5 years ago? Y / N Why? .

Do you know the health history of your birth? Y / N Home Hospital Natural Intervention .

**The following can contribute to the Vertebral Subluxation process. Please check any that apply (or applied) to you and if so when:**

**Physical Stress**

\_\_\_\_ Birth Trauma

\_\_\_\_ Slip/Fall

\_\_\_\_ Car Accidents

\_\_\_\_ Sports Injuries

\_\_\_\_ Physical Abuse

\_\_\_\_ Heavy Physical Labor

\_\_\_\_ Poor Posture

\_\_\_\_ Heavy computer use

\_\_\_\_ Repetitive movements

\_\_\_\_ Prolonged driving/standing

**Emotional Stress**

\_\_\_\_ Relationships

\_\_\_\_ Career

\_\_\_\_ Family

\_\_\_\_ Financial

\_\_\_\_ Pace of Life

\_\_\_\_ Quick temper

\_\_\_\_ Holding in feelings

\_\_\_\_ Perfectionism

\_\_\_\_ Procrastination

\_\_\_\_ Depression

**Chemical Stress**

\_\_\_\_ Environmental

\_\_\_\_ Smoker

\_\_\_\_ 2nd hand smoke

\_\_\_\_ Caffeine

\_\_\_\_ Alcohol

\_\_\_\_ “Diet/sugar-free” food

\_\_\_\_ Soda intake

\_\_\_\_ Prescription drugs

\_\_\_\_ Junk food

\_\_\_\_ Recreational drugs

What do you feel is the primary stress in your life? .

What are the 5 healthiest habits you currently choose in your life? .

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What are the 5 habits you would like to shift in your life? .

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Why is your health important to you (how will your life be better and what will you do once you reach your health goals)?

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In our office we are not only interested in your health and wellbeing but also in the health and wellbeing of your family and loved ones. Current research indicated that family health patterns often emerge throughout life that can offer useful information about the health of individuals. Please mention any health conditions or concerns you may have about your –

Spouse/partner:

Children:

Parents (include significant medical history):

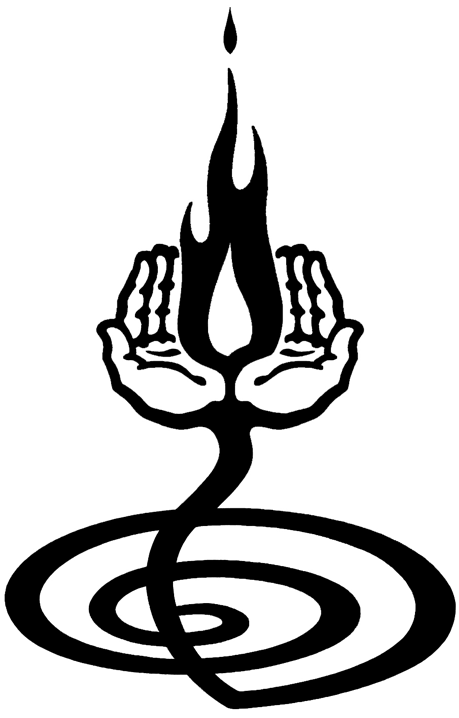
Siblings:

Financial Information: Who is responsible for this account with Northpoint Chiropractic? .

Eric Rubin DC does not offer to diagnose or treat any symptom or disease condition. Our sole purpose is to analyze your system for Subluxation patterns and to help your body release them so it can more fully express its innate ability to heal. Wellness is a dynamic equilibrium between health and disease. It exists when all organs of the body function at 100% under the direction of the nerve system and the Innate Intelligence of the body. If during your assessment a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider to serve you.

**I, , have answered the above questions to the best of my knowledge. Based on the information provided, I grant Eric Rubin DC permission to assess, locate, and release my subluxation patterns.**

**Your signature Date** .



**Terms of Acceptance / Philosophical Agreement**

When a person seeks chiropractic health care and we accept to provide such care, it is essential that we both have a clear understanding of our objectives, goals, and responsibilities in this special relationship.

The following concepts are central to the way chiropractic is practiced in this office. I share these ideas so that we can be in alignment of purpose from the very beginning.

* There is an intelligence within each of us that keeps us alive, that runs and coordinates all our physiological functions, repairs, renews, regenerates, and heals.
* The Nerve System is the main coordinating and distribution system for the body’s innate intelligence.
* Alterations or distortion in the shape, position, tone, or tension of the Nerve System (especially at the spine) will interfere with the expression of this intelligence.
* Chiropractors call this interference to the proper functioning of the Nerve System a Vertebral Subluxation. Subluxation causes alternation in nerve function and distorts the communication channels between the brain and the body. The result is a lessoning of the body’s innate ability to express its maximum health potential.
* Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.
* An Adjustment is the specific and honoring application of forces to facilitate the body’s release and integration of subluxation.
* The sole purpose of the chiropractic adjustment in this office is to assist your body to release vertebral subluxation and benefit from the restoration of clear communication channels in the body. Everyone, regardless of their symptoms or ailments, will benefit from a nerve system which is more flexible, elastic, and free of vertebral subluxation.
* We do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate major interferences to the expression of the body’s innate wisdom and to support your body to hold and integrate adjustments. If you desire advice, diagnosis, or treatment for specific diseases, we encourage you to seek the council of a medical disease care specialist.

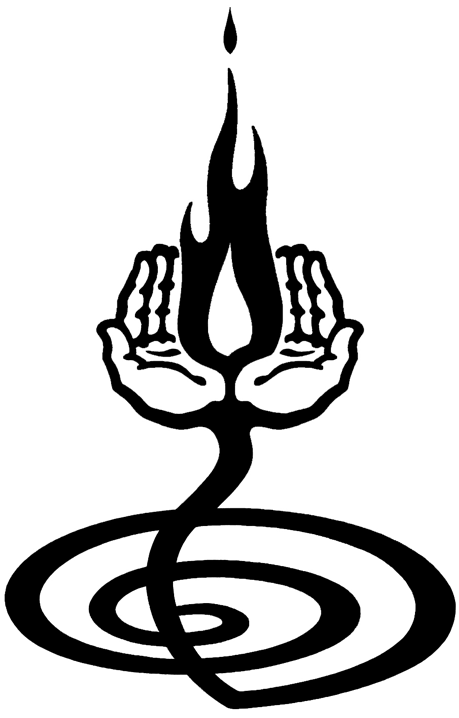
I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above statements and understand the doctor’s objectives pertaining to my care in this office. I accept chiropractic care on this basis.

Signature Date

**Consent to evaluate and adjust a minor/child:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above terms and acceptance and hereby grant permission for my child to receive chiropractic care in this office.

Signature Date



**NORTHPOINT CHIROPRACTIC**

**Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form**

1. NorthPoint Chiropractic’s Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (‘PHI’) necessary for NPC to provide treatment to me, and necessary for NPC to obtain payment for that treatment and to carry out its health care operations. NPC explained to me that the Privacy Notice will be available to me in the future at my request. NPC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.
2. NPC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following communications that will be used by NPC: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me.
4. NPC may use and/or disclose my PHI in order for NPC to treat me and obtain payment for that treatment, and as necessary for NPC to conduct its specific health care operations.
5. I understand that I have a right to request that NPC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, NPC is not required to agree to any restrictions that I have requested. If NPC agrees to requested restrictions, then the restriction is binding on NPC. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the NPC has already taken action in the reliance on this consent.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the NPC has already taken action in the reliance on this consent.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, NPC will not treat me. I further understand that if I revoke this consent, at any time, NPC has the right to refuse to treat me.
8. NPC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in NPC’s practice.

I acknowledge that I have received a copy of NPC’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with our HIPAA Compliance Officer, Blythe Olson, by phone at (415)931.9355. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

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Patients ’s Name (printed) Date Signed

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Signature (patient or legal representative)