Patient Information

Name: _____ Suffix: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Mobile Phone: _____

Email: _____

Preferred Contact Method: Primary Phone Mobile Phone Email

DOB: _____ Age: _____ Gender: Male Female

Marital Status: S M W D # of children: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Number: _____

Patient History

Reason for you visit: _____

_____

How long: _____ Cause: _____

Anything make it better/worse? _____

Describe the pain, numbness, and tingling? _____

Does it travel anywhere? _____

Does it interfere with your daily activities? Where and what? _____

Have you seen anyone else for this? Yes or No

If so, when and with whom and did it help? _____

Have you been in any auto accidents: _____ When: _____

Personal/Family Health History

Please check all that apply, specify C= current, F= family, P= previously had

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bone Fracture
- ☐ Cancer
- ☐ Concussion
- ☐ Degenerative Disc Disease
- ☐ Diabetes
- ☐ Dislocated Joint
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Disease/Problems
- ☐ Hypoglycemia
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pins/Screws/Plates
- ☐ Scoliosis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Anxiety/Depression
- ☐ Other _____

Please list all surgeries: _____

Please list current medications: _____

_____

Do you use tobacco products of any kind? _____ Type & duration: _____

Have you been under chiropractic care before? _____

If so, whom did you see and when? _____

I (we) agree to pay for the above services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are **NOT** accepted and that I am personally responsible for payment of any and all services. I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered will be immediately due and payable. Full payment of services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements can be made in advance before seeing the doctor.

New Patients: It is this office's policy that you must pay for the first 3 visits at the time of the initial visit.

Patient's Signature: _____ Date: _____

Spouse or Guardian's Signature _____ Date: _____

A Spine of All Kinds, LLC
Dr. Andrea Pinkstaff, DC, CAC

Privacy Practices Acknowledgement: HIPPA

As of April 2003, all health care providers are required by law to provide you, the patient, with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. I understand that your health information is personal, and we are committed to protecting it. I create a record of care and services for you receive. I need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speaks to me. In the course of your care as a patient at A Spine of All Kinds 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 provider or hospital if it is necessary to refer for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing record may be disclosed to another party, such as insurance carrier, HMO, PPO, or your employer.
- 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 me of interest to you.
- Patient authorization for contact regarding chiropractic care, related health services and/or related health products.
- It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health-related meetings, workshops, and products.
- The use of this information is intended to make your experience with our practice more efficient, productive, and to further enhance your access your quality health care.

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 provided health care services to you based on the orders of another health care provider.
- If we provide 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 judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclose 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 your home, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date of your last appointment. 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 practice with respect to your health information.

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 notice you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all your health information in our files.

Information that we use or disclose based on this privacy notice may be subjected to re-disclosure by the person or persons to whom we provide the information by the federal privacy rules.

This notice is effective as of April 15, 2023. If you choose not to authorize this information use, your decision will have no adverse effect on your care from A Spine of All Kinds Chiropractic or on your relationship with the staff.

Your signature indicated your authorization of this activity.

_____	_____	_____
Name (Printed Please)	Signature	Date

A Spine of All Kinds, LLC
Dr. Andrea Pinkstaff, DC, CAC

Terms of Acceptance & Consent for Care

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 understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: 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 or 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 disease or 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 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)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)