

Health History: Adult and Adolescent (ages 12 & up)

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Marital Status: Single Married Widowed Divorced Work Phone: _____

Occupation: _____ Social Security Number: _____

Spouse and Children's Names (Ages): _____

Who may we thank for referring you? _____

Medical Doctor: _____

Previous Chiropractor: _____ Date of Last Visit: _____

Practice Member's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Parent's signature required for minor children

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

Current Health Concern(s) – please circle appropriate response on each question & elaborate as needed

Do you have any current health concerns? No, here for wellness Yes

If yes, please elaborate: _____

When did you notice it? _____ How often does it occur? _____

Does it radiate? Yes No If yes, where? _____

What makes it better? _____

What makes it worse? _____

Describe how it interferes with your life, work, or hobbies: _____

Do you feel it is getting worse? Yes No If yes, how? _____

0 to 10, what is your discomfort level NOW? 0 1 2 3 4 5 6 7 8 9 10

0 to 10, what is your discomfort level AT WORST? 0 1 2 3 4 5 6 7 8 9 10 When was it last at that level? _____

Other Professionals seen for concern: _____

Treatments received and Results: _____

Do you have or have you ever had any of the following conditions? Please mark as C-Current/Today, P-Past or N-None (C's = not wellness):

High Blood Pressure	Low Blood Pressure	Diabetes, Type I	Diabetes, Type II	Pre-diabetes
Digestive Issues	Sinus Issues	Vision issues	Breathing issues	ENT Issues
Heart disease	Joint pain	Kidney Issues	Cancer	Liver/Gall bladder issues
Behavioral Issues	Depression	Tremors	Learning Disabilities	Chest pain
Neck Pain	Jaw pain/TMJ	Headaches	Mid Back pain	Low Back Pain
Extremity Pain (hand)	Extremity Pain (elbow)	Extremity Pain (shoulder)	Skin issues	Scoliosis
Extremity Pain (foot)	Extremity Pain (knee)	Extremity Pain (hip)		

Please discuss any "C" or "P" answers: _____

Please list any other conditions that you currently have which affect your health: _____

Family Health History

Please note ages with any health issues (including but not limited to heart disease, cancers, diabetes,...) are present with family relations:

Sons: _____

Daughters: _____

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

List any other issues or concerns that you want us to be aware of: _____

In this office we will perform a thorough assessment of your spine at each visit to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by inability to adapt to or resolve *physical, chemical and mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stresses – please circle appropriate response on each question & elaborate as needed

Any significant injuries or traumas during infancy that you are aware of (birth to age 5)? Yes No Unsure

Please explain: _____

Any significant falls, traumas or injuries during childhood (age 5 to 20)? Yes No Unsure

Please explain: _____

Any significant falls, traumas or injuries during adulthood? (over age 20)? Yes No Unsure

Please explain: _____

Any hospital visits for concussions, possible fractures or other traumas)? Yes No Unsure

Have you had any surgeries? Yes No Unsure

If yes, please explain: _____

Any awkward or repetitive activities with work (i.e. assembly line work, on phone, etc.)? Yes No Unsure

If yes, please explain: _____

Any hobbies that are physically strenuous or require repetitive activities (i.e. hockey, golf weightlifting, etc.)? Yes No Unsure

If yes, please explain: _____

What is your regular exercise routine? _____

How many hours of electronic technology (TV, cell phone, tablet, computer) use do you get daily? 1 2 3 4 5 6 7 8 9 10 10+

Chemical Stresses – please circle appropriate response on each question & elaborate as needed

Are you currently taking any prescription medications? Yes No

If yes, which ones? _____

Do you routinely use non-prescription medications (i.e. Tylenol)? Yes No

If yes, which ones and how often? _____

Are you currently taking supplements? Yes No

If yes, which ones? _____

Do you use tobacco? Yes (Vape, Cigarettes, Chewable, Pipe, Cigars) No

Please describe use/frequency _____

Do you drink alcohol? Yes No

Please describe use/ frequency _____

Have you been fully vaccinated? Yes No Unsure

Do you receive annual flu shots? Yes No Unsure

Do you have any known allergies? Yes No Unsure

If yes, please elaborate: _____

Please answer the following questions regarding your diet – please mark appropriate response on each question & elaborate as needed:

- Overall, how much do you eat in a day? Too little Moderate amount Too much Unsure
- Daily intake of sugar? Very little Moderate amount Too much Unsure
- Daily intake of caffeine? 0-3 servings 4-6 servings >7 servings Unsure
- Daily intake of fatty foods? 0-3 servings 4-6 servings >7 servings Unsure
- Daily fruits and vegetables? 0-3 servings 4-6 servings >7 servings Unsure
- Fast food consumption? Very little Moderate amount Too much Unsure

How much water (measured in ounces) do you drink daily? Coffee, tea, sodas, milk, juice do not count as water intake. _____

Daily goal should be half the body weight in OUNCES- i.e., weight = 180 lbs, daily water intake = 90 oz

Do you have any concerns about your diet and nutrition? Yes No Unsure

If yes, please explain: _____

Mental/Emotional Stresses – please circle appropriate response on each question & elaborate as needed

Since psychological stress has been shown to negatively affect nervous system function, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

1 – no stress 2 – a little stress 3 – moderate stress 4 – a lot of stress 5 – extreme stress

- | | | | |
|------------------------------|-------------------|-------------------------------------|-------------------|
| Regarding my life in general | 1 2 3 4 5 | Regarding my work and career | 1 2 3 4 5 |
| Regarding my relationships | 1 2 3 4 5 | Regarding my health and well-being | 1 2 3 4 5 |
| Regarding my finances | 1 2 3 4 5 | Regarding my time management skills | 1 2 3 4 5 |

How many hours of sleep do you get daily 1 2 3 4 5 6 7 8 9 10 10+

Do you feel that you have any sleep issues? Yes No

If yes, please explain: _____

Do you take time to pray or meditate regularly? Yes No

Please explain, in your own words, any areas in your life that you feel may be causing you any significant psychological stress:

Females only:

Last day of most recent menstrual cycle: _____ Is there any chance you are pregnant today? Yes No

Do you consider your cycle to be normal? Yes No

If no, please explain: _____

How many pregnancies have you had? _____ How many live births have you had? _____

Informed Consent To Chiropractic Treatment

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been repeatedly demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise potential Practice Members that there are or may be some risks associated with such processes. In particular, you should note:

- a) While rare, some persons have experienced rib fractures or muscle and ligament sprains or strains following manual spinal adjustments. More commonly, some persons may experience muscular soreness following adjustments. Muscles have memory and will try to return to the pre-adjusted state until they have been re-educated to the adjusted normal state. For this muscular soreness, Epsom salt soaks and/or magnesium oil/lotion/gel use is recommended after your initial visits.
- b) There have been alleged cases of injury to a vertebral artery following manual cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- c) There have been rare reported cases of disc injuries following cervical and lumbar manual spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused, by spinal adjustment or chiropractic treatment.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as contents of this Consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Date: _____

Practice Member's Name: _____ Witness's Name: _____

Practice Member's Signature: _____ Witness's Signature: _____

Authorization For Care of a Minor (Under 18 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic. My child may be seen with / without (circle one) my presence. If you circle **without**, please note who else may bring your child to be checked.

Child's Name: _____ Parent's Name: _____ Date: _____

Parent's Signature: _____ Witness's Signature: _____

Office Policy of Health Revolution

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best family health care available. In return, we expect you to experience improved nervous system function. It is our experience that our practice members who follow these simple guidelines obtain the best results and greatest benefits to their health.

CLINIC HOURS

Initial _____

Our day is divided into adjustment hours and assessment hours. Assessment hours include: consultations, assessments and discussion of findings with practice members. Consultations, assessments and reports should be scheduled during assessment hours only. Open adjustment hours are posted in the office and are subject to change. Since no appointment is required, we cannot tell you when it will be busy in the office or what kind of wait period there will be at any particular time. During open adjusting hours, the chiropractor may not generally be available for answering questions. An appointment is suggested if you need to discuss any concerns. Your chiropractor is Webster Technique certified and serves pregnant women. Occasionally, this may take the doctor out of the office during adjustment hours to go help a laboring mom. Additionally, we may be closed for various reasons including holidays, continuing education seminars, and vacations. Schedule changes will be posted in the office and on our Facebook page with as much advanced notice as possible, so please follow us on Facebook at facebook.com/HealthRevolutionLindale

APPOINTMENT SCHEDULING & MISSED APPOINTMENTS

Initial _____

Appointments are required only at the 1st visit due to the time needed for history review and the exam. During orientation, we will tell you how many visits you need each week (we recommend once/week on average) and what exercises you should be doing to allow for proper care, a must for spinal and postural correction to remove nerve interference during care. Appointments are not required beginning with the 2nd visit. Orientation attendance is required to have a 3rd visit. We expect Practice Members to take responsibility for their care

CHILDREN AND FAMILY

Initial _____

Once you understand that the nervous system controls and coordinates all functions of the body and subluxations interfere with nerve function, we expect that you may want everyone in your family assessed. We extend an opportunity for you to have your family checked.

FINANCIAL AGREEMENTS

Initial _____

The first visit has a set fee for the exam. The second visit is no charge. If you attend orientation and decide to continue care here, you may participate in the BOX ON THE WALL. This means you set your own visit fee. We have never refused care to anyone based on (in)ability to pay.

INTERRUPTION OF CARE / COPY OF RECORDS

Initial _____

In the unlikely event it becomes necessary to discontinue care for any reason, a copy of your records is available for a \$10 fee. The fee is for the thumb drive that it is loaded onto.

REMEMBER

Initial _____

Spinal correction and healing takes time. If you do not feel satisfied with your body's responses, please make a consultation appointment outside adjusting hours to discuss this with your doctor. We want you to obtain the most from your chiropractic care.

PRACTICE MEMBER ORIENTATION

Initial _____

We provide orientation at least twice a month. Orientation is required to be eligible for continuing care here. There is no charge for orientation and during orientation, the home exercises are demonstrated.

REFERRALS/REVIEWS

Initial _____

The successes of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like to invite to our office or the orientation, please let us know. Additionally, should you have someone in another town that you feel would benefit from an assessment by a chiropractor, we would be happy to provide you with names of doctors in their area.

We appreciate your 5 star reviews of our office on Facebook, Yelp, and Google. We strive for excellence so if you do not feel that you can provide the highest rating, we would appreciate the feedback in person allowing an opportunity for improvement prior to anything being posted online.

I have read and understand the above policies and agree to abide by them.

Signature

Date

Witness

Date

Probationary Practice Member Expectations

I agree to the following terms for my child’s care beginning on _____, 20__ :

Initial

_____ I understand that a nonrefundable fee due on first visit includes a focused exam and the first adjustment visit. There is no charge for the second adjustment visit. I understand that the fee is \$149 for an individual or \$199 maximum for an entire family. I understand that family is defined at Health Revolution Lindale, PLLC as the head of house hold and legal dependents. I agree that if I decline to accept doctor recommendations for care or if the doctor finds an issue contraindicating the chiropractic adjustment, I am responsible for paying an \$125 exam fee for exams performed and there will be no adjustments.

_____ I understand that no potential Practice Member(s) are adjusted without a completed history and spinal assessment and that if imaging is warranted, no manual adjustments will be performed until imaging has been reviewed whether it be imaging ordered at Health Revolution Lindale, PLLC or imaging completed prior to a first visit at this office.

_____ I understand we must attend an orientation session prior to adjustment visit #3.

_____ I understand following the 1st visit appointments are not necessary for an adjustment unless my child is exhibiting immune activity.

_____ I understand that Health Revolution Lindale, PLLC is out of network with all health insurance companies. I understand that the fees (mostly because YOU, the practice member set them) at Health Revolution Lindale, PLLC as detailed above are not considered reasonable or customary by insurance companies and that our services are not eligible for reimbursement, however, some Health Savings Accounts (HSA) may provide reimbursement and I understand that such reimbursement requests are my responsibility. I understand that insurance does not cover wellness or maintenance care.

_____ I understand that beginning with visit #3 and having attended orientation, I may set my own fees for care and that receipts will not be supplied. My cancelled check from the BOX ON THE WALL will serve as my receipt.

_____ I agree to make my initial fee payment with cash, check, or credit card (MC, Visa, Discover, American Express). I agree to pay in CASH if check is returned for insufficient funds with a \$35 NSF fee.

_____ I / We will not skip any of the recommended visits during each paid period of care.

_____ I / We agree to perform exercises assigned by Health Revolution’s staff as prescribed.

_____ I / We agree to notify Health Revolution’s staff of any changes to health status following first visit.

_____ I / We understand that chiropractic care is not about relief of pain but that it is about optimizing the function of my nervous system within the limitations of matter and that many have experienced the side effect of pain relief from chiropractic care. I / We understand, pain is caused by inflammation and consumption of anti-inflammatory foods like turmeric and ginger are recommended on a daily basis.

I ACCEPT / DO NOT ACCEPT the recommendations of the staff at Health Revolution Lindale, PLLC.
(circle one)

Practice Member Name (printed) _____

Date: _____

Practice Member Signature _____

Practice Member Privacy Consent Form

For Collection, Use and Disclosure of Personal Information

We are not a covered entity subject to HIPAA because we do not file or accept any insurance, however, privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our Practice Members.

In this office, the Privacy Information Officer is:

Dr. N. LeAnne Davis, DC

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses Practice Members' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient Practice Member care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options, including which we are aware of that are available outside our office
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services
- to communicate with other treating health-care providers, including specialists and referring doctors
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of Practice Members' charts and records to governing bodies in a timely fashion
- to permit potential purchasers, practice brokers or advisors to evaluate the practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale.
- to deliver your charts and records to the office's insurance carriers to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for requested by the Texas Board of Chiropractic Examiners
- to invoice for services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law
- to verify your attendances through office sign-in sheets

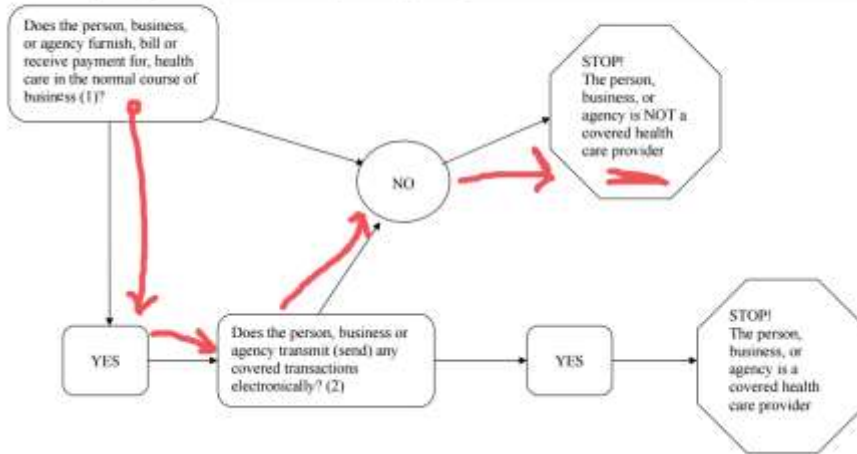
By signing the consent section of this Practice Member Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

While we are not a covered entity for compliance with the Health Insurance Portability and Accountability Act (HIPAA), we will comply with requests for records from regulatory authorities under the terms of the Health Insurance Portability and Accountability Act (HIPAA) and for the defense of a legal issue.

<http://hipaanews.org/Documents/CoveredEntitycharts.pdf>

hipaanews.org/Documents/CoveredEntitycharts.pdf

Is a person, business, or agency a covered health care provider?



Our office will not under any conditions supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process

Practice Member Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that **Health Revolution Lindale , PLLC** can collect, use and disclose personal information about the mentioned person below as set out above in the information about the office's privacy policies.

I have received a copy of the Privacy Information Sheet.

Signature

Print Name

Date

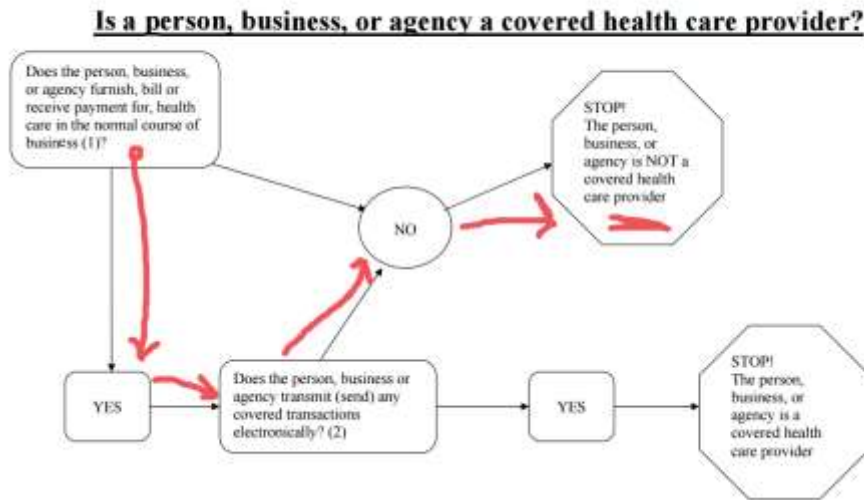
Signature of Witness

Privacy Information Sheet

How To Access the Privacy Process in Our Office

While we are not a covered entity for compliance with the Health Insurance Portability and Accountability Act (HIPAA), privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

hipaanews.org/Documents/CoveredEntitycharts.pdf



Our privacy information officer can be reached at:

Dr. LeAnne Davis DC
1816 S Main Suite B3, PO Box 2224
Lindale TX 75771
OFFICE: 903-882-8845, FAX: 903-881-5119
healthrevolutionlindale@gmail.com

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you do have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax or email.

Our privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Texas Board of Chiropractic Examiners. We have included all the necessary contact information listed below.

Phone: (512) 305-6700
Fax: (512) 305-6705

<https://www.tbce.state.tx.us/>

Our Privacy Code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.