Thank you for choosing One Life Chiropractic!

To best serve you as a patient, we have summarized our office's mission, philosophy, and policies below. **Please initial each statement as confirmation that you have read them**. If you have any questions, our staff and providers will be happy to answer them!

____ **Our Mission**: to educate and empower you to live in optimal wellness! With chiropractic as our main focus, our goal is to keep your nervous system and spine as our priority. The chiropractors at One Life specialize in Upper Cervical care and Low Force/Tonal adjusting to best serve our patients, but also utilize nutrition and wellness care when needed.

____ **Running Late?** Please be on time for your scheduled appointments. Arriving late pushes our schedule back for other patients, forcing them to wait. We love being notified if you will not be on time- feel free to call or text us! If you do arrive past your appointment time, you may need to wait while other patients who arrived on time are seen first.

____ **Need to Cancel?** We request a minimum of a 24 hour notice for all appointment cancellations and rescheduling. Our schedules are often full and this helps us keep availability for all patients. Short notice or missed appointments will be subjected to a charge of $50.00. Repeatedly missed appointments may result in dismissal from care.

____ **Payment for Service**: Payment is expected in full at time of service. Our office accepts payment in cash, credit, debit, and check. At this time, we also accept BCBS/Excellus insurance plans that include chiropractic care as a benefit. If you have a check returned, a processing fee of $30.00 will be charged.

____ **Wellness Plans**: Financial plans are offered as a convenience to our patients and allow us to decrease our billing costs through auto payments. They are in no way a binding contract. If you need to change billing information or change your plan, it will be your responsibility to inform our staff. If applicable, all balances will be owed or reimbursed as appropriate.

____ **Continuing Education/Provider Absence**: Our providers are required to attend seminars and conferences throughout the year to keep their licenses active, and further their knowledge about chiropractic technique and wellness. We will be sure to let you know ahead of time if there are days when your provider may not be in the office. If our providers are out of the office, we will provide alternative days to schedule.

By signing below, I am confirming that I have been provided with an opportunity to ask questions about all office procedures and protocols, and agree to the above statements. Thank you for joining to One Life Family ☺

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments, specifically high velocity adjusting.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at One Life Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____
Patient or Authorized Person's Signature Date

CBCT/Imaging Studies

Although minimal, our in-office CBCT imaging does expose patients to radiation. The amount is much less than a standard x-ray. Please complete this section and see our staff for if you would like any more information.

☐ If applicable, the first day of my last menstrual cycle was on ____-____-____ [Date]
☐ I acknowledge, to the best of my knowledge, I am not pregnant.
By my signature below I am acknowledging that the doctor and or staff member has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____
Patient or Authorized Person's Signature Date

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **One Life Chiropractic** to use and/or disclose certain protected health information (PHI) about me for treatment, payment and/or healthcare operations (TPO) as listed in the extended Notice of Privacy Practices. Examples include date(s) of services, type of services, and treatment details.
The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
I understand that I do not have to sign this authorization in order to receive care from **One Life Chiropractic.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient, and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **One Life Chiropractic 890 D Westfall Rd Rochester, NY 14618**

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable
(Patient/guardian: must be offered a signed copy of this authorization form)

Medical Information Release Form (HIPAA Release Form) for One Life Chiropractic

Name: _____ Date of Birth: _____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examinations rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone besides me

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ , (*times*)_____

Appointment Reminders

Our electronic records system allows us to send appointment reminders.
Would you like to opt in for these reminders 24 hours before your appointments?

[ ] yes

[ ] by text [ ] by email [ ] both

[ ] no

Would you like to receive emails with event information or a newsletter from our office?

[ ] yes [ ] no

Signed: _____ Date: ____/____/_____

Welcome to One Life Chiropractic!

Date:

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ Gender/Sex: _____

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ❑ Single ❑ Married Insurance Company: _____ Member ID: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of children and Ages: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: First: _____

Second: _____ Third: _____ Fourth:_____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number:**

First (chief complaint): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is IT at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ On and off during the day **OR** ☐ On and off throughout the week

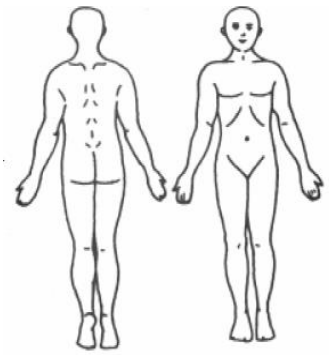
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes

If yes, when: _____ by who? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

Please identify any past or present jobs that have imposed any physical or emotional stress on you and your body:

PLEASE identify ALL PAST and **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	WHO PROVIDED CARE?
INJURIES/ACCIDENTS →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverages: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies /Recreational Activities/Exercise: How does your present problem affect these?

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sisters ❑ brothers ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any hereditary conditions the doctor should be aware of? ❑ No ❑Yes: _____

Do you have any specific expectations or goals for care in our office?

I hereby authorize payment to be made directly to One Life Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to One Life Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Who can we thank for referring you to One Life? _____

Diagnoses and Symptoms

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for past **C** for current **N** for never

____ Broken Bones	____ Headache	____ Swollen/Painful Joints	____ Digestive Problems	____ Liver Problems
____ Fractures	____ Neck Pain	____ Sinus/Drainage Problems	____ Colon Problems	____ Hepatitis (A,B,C)
____ Dislocations	____ Jaw Pain, TMJ	____ Frequent Colds/Flu	____ Diarrhea/Constipation	____ Prostate Problems
____ Osteoarthritis	____ Shoulder Pain	____ Tremors	____ Depression	____ Impotence/Sexual Dysfxn
____ EDS/Hypermobility	____ Elbow/Wrist Pain	____ Epilepsy/Convulsions	____ Irritability	____ Menstrual Pain/PMS
____ Osteoporosis	____ Upper Back Pain	____ Chest Pain	____ Anxiety	____ Menopause Problems
____ Rheumatoid Arthritis	____ Mid Back Pain	____ Pain w/ Cough, Sneeze	____ Mood Changes	____ Bed Wetting
____ Diabetes	____ Low Back Pain	____ Skin Problems	____ ADD/ADHD	____ Trouble Sleeping
____ Pregnancy (current?)	____ Hip Pain	____ Double Vision	____ Learning Delays	____ Anemia
____ Heart Attack	____ Knee Pain	____ Blurred Vision	____ Eating Disorder	____ Memory Concerns
____ Stroke/TIA	____ Ankle/Foot Pain	____ Ringing in Ears	____ Mental Health Diagnosis	____ Change in Appetite
____ Dizziness	____ Back Curvature	____ Hearing Loss	____ Asthma	____ Weight Gain
____ Loss of Balance	____ Scoliosis	____ Allergies	____ Difficulty Breathing	____ Weight Loss
____ Fainting	____ Concussion	____ Ulcers	____ Lung Problems	____ Hypersensitivity: Light
____ Numbness/Tingling Arms, Hands, Fingers		____ Heartburn	____ Kidney Problems	____ Hypersensitivity: Sound
____ Numbness/Tingling Legs, Feet, Toes		____ Heart Problems	____ Incontinence	____ Hypersensitivity: Touch
____ Tumor		____ High Blood Pressure	____ Gallbladder Problems	____ Hypersensitivity: Smell
____ Cancer, specify type/location:		____ Low Blood Pressure	____ Stomach/Abdominal Pain	____ Hypersensitivity: Taste

Please utilize this space to elaborate or clarify on your above diagnoses:

Medications and Supplements

Please list all prescription and non-prescription medications and supplements you are currently utilizing:

Name Dose Frequency What are you taking this for? Is this helping?

One Life Chiropractic

Patient's Name: _____ Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration/Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform