Revelation Chiropractic Health Profile

Name_____ Date_____/_____ Age_____ Male / Female

Address_____ Apt _____ City_____ Zip_____

Phone Numbers: Home_____ Cell_____

Circle best number to reach you at: Home Cell Date of Birth_____/_____/_____

Occupation_____ Email Address_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you?_____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of severity 1=mild 10=unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE_____
_____
_____

IF YOU ARE EXPERIENCING PAIN, IS IT _____SHARP _____DULL

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? ____YES ____ NO

IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE_____

_____

SINCE YOUR PROBLEM STARTED, IS IT ____About the Same ____ Getting Better ____Getting Worse

WHAT MAKES IT WORSE?_____

WHAT HAVE YOU DONE THAT MAKES IT FEEL BETTER?_____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ____Chiropractor ____Medical Doctor ____Other

WHO AND WHEN?_____

LIST SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL MEDICATIONS YOU ARE ON_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE ____YES ____NO

IF YOU HAVE, DR. & DATE_____

HAVE YOU EVER BEEN UNCONSCIOUS ____YES ____NO FRACTURED A BONE? ____YES ____NO

IF YES, PLEASE DESCRIBE_____

ANY OTHER BODILY TRAUMA?_____

PLEASE CIRCLE ANY AND ALL CURRENT PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS

ASTHMA	ARTHRITIS	TMJ	CHRONIC FATIGUE
EPILEPSY	GASTRIC REFLUX	HEART DISORDERS	LUPUS
ULCERS	SCIATICA	IRRITABLE BOWL	NAUSEA
DIZZINESS	NUMBNESS IN ARMS	DISC PROBLEMS	MENSTRUAL DISORDER
KIDNEY PROBLEMS	NUMBNESS IN LEGS	LIVER DISEASE	NECK PAIN
HEADACHES	NUMBNESS IN HANDS	LOW BACK PAIN	MIGRAINES
VERTIGO	NUMBNESS IN FEET	MID BACK PAIN	STIFFNESS IN NECK
CHEST PAINS	EAR INFECTIONS	STOMACH DISORDER	HIP PAIN
ARM PAINS	GRATING IN NECK	LEG PAINS	ANXIETY
NERVOUSNESS	SHOULDER PAIN	FAINTING	CHRONIC SINUS

OTHER_____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW / HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

Practice Member Information (Must be Completed Before Services can be Rendered)

NAME: _____
First Middle Last

ADDRESS:

_____
Street Apt. City State zip code

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY: _____ Marital Status: _____

Date of Birth: _____

Contact in case of emergency: _____ Phone # _____

NAME OF PRIMARY INSURANCE CARRIER:

_____

Name of insured _____ Insured Date of Birth_____

Insured Social Security: _____

NAME OF SECONDARY INSURANCE CARRIER:

_____

Name of insured _____ Insured Date of Birth _____

Insured Social Security: _____

Insurance Policies and Fee Schedules

- **Consultation-**includes practice member history. This service is complimentary.
- **Examination (new patient or established patient)-**includes one of more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $50-$75.
- **Chiropractic Adjustment –** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result it does not mean that the adjustment has not taken place. $40-$60.
- **X-rays –** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care $40 per view.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Chad McMahan, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other Arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____ Date _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are done by hand in this office.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE ***VERTEBRAL SUBLUXATIONS.***
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF DISCOVER CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

PRINT YOUR NAME HERE _____ DATE _____

SIGNATURE _____ YOUR AGE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT DISCOVER CHIROPRACTIC

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE · DO NOT WRITE BELOW THIS LINE · DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐ 10-11	☐78	☐ 1/24	12.5
☐ 12-13	☐	☐ 1/20	15
☐ 14-15		☐ 1/15	20
☐ 16-17		☐ 1/10	30
		☐ 2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐ 14-15	☐70	☐ 1/10	20
☐ 16-17	☐	☐ 2/15	30
☐ 18-19		☐ 3/20	40
☐ 20-21		☐ 2/10	50
☐ 22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐ 14-15	☐70	☐ 1/10	20
☐ 16-17	☐	☐ 2/15	30
☐ 18-19		☐ 3/20	40
☐ 20-21		☐ 2/10	50
☐ 22-23			

MA 300 Size 8x10

Other View _____

CM _____ Kvp _____

MAS _____ MA _____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐ 22-23	☐80	☐ 1/15	20
☐ 24-25	☐	☐ 1/10	30
☐ 26-27		☐ 2/15	40
☐ 28-29		☐ 2/10	50
☐ 30-31		☐ 1/4	75
☐ 32-33		☐ 3/10	90
☐ 34-35		☐ 2/5	120
☐ 36-37		☐ 1/2	150

MA 300 Size 14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐ 26-27	☐88	☐ 3/10	30
☐ 28-29	☐90	☐ 2/10	40
☐ 30-31	☐92	☐ 1/4	50
☐ 32-33	☐94	☐ 2/5	70
☐ 34-35	☐96	☐ 1/2	90
☐ 36-37	☐	☐ 3/5	120
☐ 38-39		☐ 4/5	160
☐ 40-41		☐ 1	200
☐ 42-43		☐ 1 1/2	
		☐ 2	

MA 200 Size 14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐ 16-17	☐75	☐ 1/20	17
☐ 18-19	☐	☐ 1/15	22
☐ 20-21		☐ 1/10	30
☐ 22-23		☐ 2/15	40
☐ 24-25		☐ 2/10	50
☐ 26-27		☐ 1/4	75
☐ 28-29		☐ 3/10	90
☐ 30-31		☐ 2/5	120

MA 300 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐ 20-21	☐76	☐ 1/15	40
☐ 22-23	☐78	☐ 1/10	50
☐ 24-25	☐80	☐ 2/15	75
☐ 26-27	☐	☐ 2/10	90
☐ 28-29		☐ 1/4	120
☐ 30-31		☐ 3/10	150
☐ 32-33		☐ 2/5	170
☐ 34-35		☐ 1/2	210
☐ 36-37		☐ 3/5	
☐ 38-39		☐ 4/5	
☐ 40-41		☐ 1	
☐ 42-43		☐ 1 1/2	
		☐ 2	

MA 300 Size 14x17

Notes: _____

CA Initials _____