

# Atkinson Chiropractic Health Questionnaire

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Birthdate \_\_\_\_\_  
Male/Female Age \_\_\_\_\_ SS# \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Employer's Phone# \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Marital Status: M W D S Spouse Name \_\_\_\_\_ No# of Children \_\_\_\_\_  
Name of Children \_\_\_\_\_

1. Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?  
\_\_\_\_\_
2. Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?  
Frequently/only when you hurt/1 x monthly/never
3. When was your last complete spinal examination including x-rays? \_\_\_\_\_  Never
4. Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem?  Yes  No
5. Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck?  Yes  No
6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back?  Yes  No
7. Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent
8. Stress will cause you to accelerate spinal damage. Rate your stress level over the last 3 months.  
Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight
9. Please circle or list any health symptoms or health complaints you are experiencing.  
Neck pain L/R      Arm pain/Numbness L/R      Asthma      Thyroid  
Back Pain L/R      Leg pain L/R      Cancer      Allergies: \_\_\_\_\_  
Mid-back pain L/R      Headaches/Migraines      Constipation      \_\_\_\_\_  
Lower-back pain L/R      Diabetes I/II      Menstrual pain      \_\_\_\_\_
10. Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (use back if necessary)  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
11. Please list any surgeries you have had. \_\_\_\_\_
12. Daily trauma, auto accident(s), and work injuries can cause serious spinal problems.  
When was your most recent injury at home? \_\_\_\_\_ Car accident? \_\_\_\_\_ Slip or fall? \_\_\_\_\_
13. Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant?  Yes  No
14. Do you smoke?  Yes  No
15. Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in:  Back  Stomach  R Side  L Side
16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 6x @wk      17. Are you ?  Right Handed  Left Handed
18. Please list vitamins/supplements you take: \_\_\_\_\_
19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely?  
 Yes  No

Your preferred method of payment for care (please circle):      Self-Pay      or      Insurance  
Your preferred way of contact about office changes (please circle)      Email      or      Text Message      Carrier: \_\_\_\_\_

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian): \_\_\_\_\_ 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 of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that 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 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to 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 a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has 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.

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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 Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

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Signature

Date

Atkinson Chiropractic Wellness Center  
15 Commerce Dr. # 108 Grayslake, IL 60030  
(847) 223-3158

## *Atkinson Chiropractic*

### **Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment.**

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Atkinson or your relationship with our staff.

Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (printed)

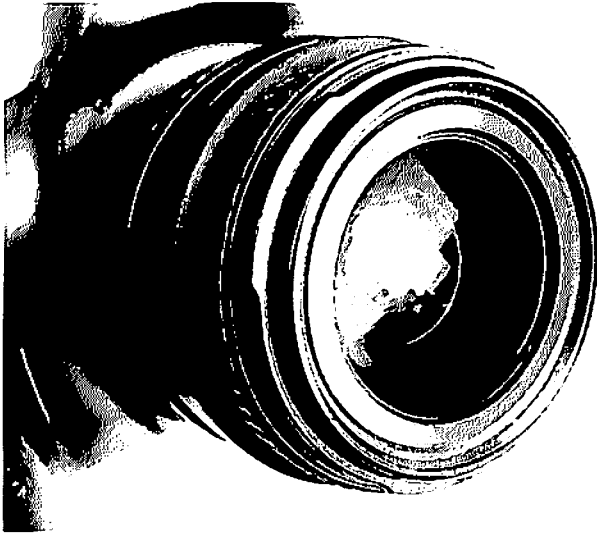
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow reasonable time for the change in our procedures to be completed.

Justin E. Atkinson, D.C.  
15 Commerce Dr. #108  
Grayslake, IL 60030

Phone (847) 223-3158  
Fax (888) 481-4758  
atkinsonchiropractic@gmail.com



**Atkinson  
Chiropractic  
Wellness Begins Here  
(847) 223-3158**

**This is to acknowledge my approval to allow Dr. Atkinson to take my picture for the sole use of patient file identification only. This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.**

**Patient Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**Our purpose is to educate and adjust families toward optimal health with natural chiropractic care.**

## The New Federal HIPPA Laws

How your health information may be used:

**TO PROVIDE TREATMENT** – We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

**TO OBTAIN PAYMENT** – We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

**TO CONDUCT HEALTH CARE OPERATIONS** – Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

**IN PATIENT REMINDERS** – Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or service that may of interest to you or your family.

**ABUSE OR NEGLECT** – We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

**PUBLIC HEALTH AND NATIONAL SECURITY** – We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

**FOR LAW ENFORCEMENT** – As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstance, if you are a victim of a crime or in order to report a crime.

**FAMILY, FRIENDS AND CAREGIVERS** – we may share your health information with those you tell us will be helping you with you home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your information only when it will be important to those participating in providing your care.

**TO CORONERS, FUNERAL DIRECTORS AND MEDICAL EXAMINERS** – We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

**MEDICAL RESEARCH** – Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION** – Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization, in writing at any time.

### Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

**RESTRICTIONS** – You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

**CONFIDENTIAL COMMUNICATIONS** – You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family member present or through mail communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

**INSPECT AND COPY YOUR HEALTH INFORMATION** – You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

**AMEND YOUR HEALTH INFORMATION** – You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

**DOCUMENTATION OF HEALTH INFORMATION** – You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

**REQUEST A PAPER COPY OF THIS NOTICE** – You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

### Privacy Policy Acknowledgement

I have received the Notice of Privacy Policies and I have been provided with an opportunity to review it.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_