Patient Name: _____ Date: _____

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

Home phone: _____ Wok Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D W

Social Security # _____

Occupation: _____

Employer: _____

Referred by: _____

Have you ever received Chiropractic care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Reasons for Seeking Chiropractic Care:

Primary Reason

_____

Secondary Reason

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaints?

_____

_____

_____

3. Past health history:
   A. Please indicate if you have a history of any of the following:
      ☐ Anticoagulant use ☐ Heart Problems/High blood pressure/chest pain ☐ Bleeding problems
      ☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders
      ☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TIA's
      ☐ None of the above ☐ Other:
   B. Previous Injury or Trauma:

      _____

      Have you ever broken any bones? Which?

      _____

   C. Allergies: _____

      _____

D. Medications:

Medication Reason for Taking

E. Surgeries:

Date Type of Surgery

F. Female/Pregnancies and Outcome

Pregnancies/Date of Delivery Outcome

4. **Family Health History:**

Do you have a family history of: (Please indicate all that apply)

☐ Cancer ☐ Stroke's/TIA's ☐ Headaches ☐ Cardiac Disease ☐ Neurological Disease

☐ Adopted/Unknown ☐ Cardiac Disease below age of 40 ☐ Psychiatric Disease ☐ Diabetes

☐ Other _____ ☐ None of the Above

Deaths in Immediate Family: _____

Cause of parents or siblings death Age at Death

Social and Occupational History:

A. Job Description:

B. Work Schedule:

C. Recreational Activities:

D. Lifestyle (Hobbies, level of exercise, alcohol and tobacco use, drug use and diet:

REVIEW OF SYMPTOMS

Have you had any of the following pulmonary (lung-related) issues?
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other: _____ ☐ None of the Above

Have you had any of the following cardiovascular (heart-related) issues or procedures?
☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease problems
☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular Heartbeat ☐ Other _____ ☐ None of the Above

Have you had any of the following neurological (nerve-related) issues?
☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of siezures ☐ Headaches ☐ Memory loss
☐ One sided decreased feeling in the face or body ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell ☐ Strokes/TIAs
☐ Other _____ ☐ None of the Above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?
☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐ Other _____
☐ None of the Above

Have you had any of the following renal (kidney-related) issues or procedures?
☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other _____ ☐ None of the Above

Have you had any of the following gastroenterological (stomach-related) Issues?
☐ Nausea ☐ Difficulty Swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal Hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or Black tarry stools ☐ Vomiting Blood
☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ None of the Above

Have you had any of the following hematological (blood-related) issues?
☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV Positive
☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia
☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy
☐ Regular aspirin use ☐ Other _____ ☐ None of the Above

Have you had any of the following dermatological (skin-related) issues?
☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other _____ ☐ None of the Above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?
☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Spinal Surgery ☐ Joint surgery
☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal implants ☐ Other _____ ☐ None of the Above

Have you had any of the following psychological issues?
☐ Psychiatric diagnoses ☐ Depression ☐ Suicidal Ideations ☐ Bipolar disorder ☐ Homicidal Ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other _____ ☐ None of the Above

Is there anything else in your past medical history that you feel is important for your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with the chiropractic care, in accordance with this state's statutes. If my Insurance will be billed, I authorize payment of medical benefits to Joshua Sundberg DC/ Sundberg Family Chiropractic for services performed.

Patient or Guardian signature _____

Date _____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFEULLY.

This notice of privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information that may identify you and that related to you past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be sued and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sing your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration's requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

4403 W. Michigan Ave. Kalamazoo, MI 49006
Phone 269-375-6565 Fax 269-375-7168
www.sundbergfamilychiro.com

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Josh Sundberg and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Josh Sundberg and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:	To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)
_____	_____
Print Patients Name	Print Patients Name
	_____
	Print Name of Representative
_____	_____
Patients Signature	Patients Signature

INSURANCE AND FINANCIAL INFORMATION

If we can verify that you have coverage for care at this office, we will be glad to bill your insurance company for you. If your insurance company does not pay, or does not pay the full amount that we billed, you will be responsible to pay the balance upon receipt of insurance denial.
If you need to make special arrangements for payment, please let us know before you see the doctor today. Thank you.

FIRST HEALTH INSURANCE CO. _____

Policy number: _____ Group # _____

If not your name, who is policy holder: _____

Policy holders relationship to you: Spouse / Domestic Partner / Parent / Other: _____

Date of birth of policy holder: _____/_____/_____

SECOND HEALTH INSURANCE CO. _____

Policy number: _____ Group # _____

If not your name, who is policy holder: _____

Policy holders relationship to you: Spouse / Domestic Partner / Parent / Other: _____

Date of birth of policy holder: _____/_____/_____

Please check one below:

☐ **"I will pay cash for my care."**
I understand that payment is due at time of service unless other written arrangements are made in advance.

☐ **"Bill my insurance for my care and I agree to pay what they reject."**
I understand that my insurance coverage is a contract between me and my insurance company. If my insurance does not pay, or does not pay in full, I agree to pay the balance due at the time of insurance denial.

Print your name here: _____

Sign here: _____ Date _____

A note about this office: According to Michigan law, your health records, including all x-rays are the permanent property of this office. We will make copies of your written records and loan x-rays out for review, but require that the x-rays are delivered back to our office by mail or in person. Thank you

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day