The ROOTS CHIROPRACTIC

8209 Natures Way | Unit 115
Lakewood Ranch, Florida 34202
(941) 877.1507

Name_____Date_____/_____/_____Age_____Male/Female

Address_____City_____State_____Zip_____

Phone: Home_____ Cell_____ Cell Phone Provider_____

Email_____Date of Birth_____/_____/_____

Employer's Name_____ Position_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

Who may we thank for referring you?_____

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._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

ADD/ADHD	**CHEST PAIN**	**HEADACHES**	**LIVER DISEASE**	**NUMBNESS IN FEET**
ALLERGIES	**CHRONIC FATIGUE**	**HEART PROBLEMS**	**LOW BACK PAIN**	**NUMBNESS IN HAND**
ANXIETY	**COLIC**	**HYPERTENSION**	**LUPUS**	**NUMBNESS IN LEGS**
ARM PAIN	**DEPRESSION**	**HIP PAIN**	**MENSTRUAL ISSUES**	**PREGNANCY ISSUES**
ARTHRITIS	**DIZZINESS**	**IMMUNE DEFICIENT**	**MID BACK PAIN**	**SCIATICA**
AUTISM	**DISC PROBLEM**	**INFERTILITY**	**MIGRAINES**	**SHOULDER PAIN**
AUTOIMMUNE	**EAR INFECTIONS**	**IRRITABLE BOWEL**	**NAUSEA**	**SINUS INFECTIONS**
BLADDER PROBLEM	**EPILEPSY**	**KIDNEY PROBLEMS**	**NECK PAIN**	**STOMACH ISSUES**
BEDWETTING	**FIBROMYALGIA**	**KNEE PAIN**	**NERVOUSNESS**	**THYROID PROBLEMS**
CANCER	**GASTRIC REFLUX**	**LEG PAIN**	**NUMBNESS IN ARMS**	**VERTIGO**
OTHER:_____	_____	_____	_____	_____

CIRCLE ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD

STROKE HEART DISEASE SPINAL SURGERY SEIZURES SPINAL FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON_____

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YES, DR AND DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_____

I AUTHORIZE DR. LOGAN SWAIM AND/OR DR. LAURA SWAIM AND ANY AND ALL THE ROOTS CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY THE ROOTS CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR/CHILD

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOU CHIROPRACTIC HEALTH RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WITH 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 THE ROOTS 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.

_____ _____

PRINT YOUR NAME HERE DATE

_____ _____/_____/_____

SIGNATURE BIRTH DATE

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

_____ _____

SIGNATURE DATE

Sex: ☐ **Male** ☐ **Female**

☐Lat Cervical ☐ **Flex/Ext**

CM	Kvp	Time	MAS
☐10-11	☐ 78	☐ 1/24	12.5
☐12-13	☐ 80	☐ 1/20	15
☐14-15	☐ 82	☐ 1/15	20
☐16-17	☐ 84	☐ 1/10	30

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐ 1/10	20
☐16-17	☐72	☐ 2/15	30
☐18-19	☐74	☐ 3/20	40
☐20-21	☐76	☐ 2/10	50

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐ 1/10	20
☐16-17	☐72	☐ 2/15	30
☐18-19	☐74	☐ 3/20	40
☐20-21	☐76	☐ 2/10	50

MA 300 Size 8x10

Other

View _____

CM _____ Kvp ____

MAS _____ MA _____

Size _____

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐ 75	☐1/20	17
☐18-19	☐ 77	☐1/15	22
☐20-21	☐ 80	☐1/10	30
☐22-23	☐ 82	☐2/15	40
☐24-25	☐ 84	☐2/10	50
☐26-27	☐ 86	☐1/4	75
☐28-29	☐ 88	☐3/10	90
☐30-31	☐ 90	☐2/5	120

MA 300 Size 14x17

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐ 80	☐1/15	20
☐24-25	☐ 82	☐1/10	30
☐26-27	☐ 84	☐2/15	40
☐28-29	☐ 86	☐2/10	50
☐30-31	☐ 88	☐1/4	75
☐32-33	☐ 90	☐3/10	90
☐34-35	☐ 92	☐2/5	120
☐36-37	☐ 94	☐1/2	150

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	☐82	☐2/10	90
☐28-29	☐84	☐1/4	120
☐30-31	☐86	☐3/10	150
☐32-33	☐88	☐2/5	180
☐34-35	☐90	☐1/2	200
☐36-37	☐92	☐3/5	220
☐38-39	☐94	☐4/5	230
☐40-41	☐96	☐1	250
☐42-43	☐98	☐1 ½	280
☐44-45	☐100	☐2	300

MA 300 Size 14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	75
☐34-35	☐96	☐1/2	90
☐36-37	☐98	☐3/5	120
☐38-39	☐100	☐4/5	160
☐40-41	☐102	☐1	200
☐42-43	☐104	☐1 ½	220

MA 300 Size 14x17

Notes:_____

_____

_____

_____

_____

PRINCIPLED DOCTORS REPORT is scheduled for:

_____

DAY **DATE** **TIME**

CA Initials:

_____

PRACTICE MEMBER INFORMATION

(must be completed before services can be rendered)

NAME:_____
First Middle Last

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY NUMBER:_____ MARITAL STATUS:_____

DATE OF BIRTH:_____

IN CASE OF EMERGENCY CONTACT:_____ PHONE NUMBER_____

NAME OF PRIMARY INSURANCE CARRIER:_____

NAME OF INSURED:_____ INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

DO YOU HAVE A HSA/FSA? (Health/Flexible Savings Account) ☐ YES ☐ NO

NAME OF SECONDARY INSURANCE CARRIER:_____

NAME OF INSURED:_____ INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

Insurance Policies and Fee Schedule

- **Consultation**: includes new practice member history. This service is complimentary.
- **Specific, Scientific Chiropractic Assessment**: (new or established practice member): includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $75-$95.
- **Specific, Scientific Chiropractic Adjustment**: The actual re-alignment of the misaligned 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. $50-$70.
- **Chiropractic Postural 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 a period of care. $50 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Logan Swaim, D.C. or Laura Swaim, 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_____

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process it to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARILY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT NAME

_____ _____

SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

_____ _____

PARENT/GUARDIAN'S NAME **DATE**

_____ _____

RELATIONSHIP TO MINOR/CHILD **DATE**

_____

WITNESS SIGNATURE (OFFICE STAFF)

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

PLEASE PRINT YOUR NAME HERE **DATE**

PLEASE PLACE AN "X" IN THE APPROPRIATE BOXES BELOW

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SINUS TROUBLE					
SURGERIES					
TMJ					