Ohana Chiropractic and Wellness Center

Personal Information

Full name:	**Date:**
Address: City State Zip	
Home phone:	
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Hair color: **Eye color:**	**Birth place:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	

Who may we thank for referring you? _____

What Brought You Into This Office?

Please list your health concerns according to their severity or priority of care	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time symptom is present
1.					
2.					
3.					
4.					

What have you done for each condition? Was it of benefit?

_____
_____
_____
_____
_____

Do you wear: □ Orthotics □ Heel lifts □ Arch Supports If so, how long have you had them? _____

Are you currently dieting? □ Yes □ No If so, what program and for how long? _____

Briefly describe your current eating habits:_____
_____
_____
_____

Exercise? □ Yes □ No If yes, how often and what type? _____

How much water do you drink daily? _____

On average, how many hours of sleep do you get each night? _____ Do you feel rested after sleeping? □ Yes □ No

Health History

Please mark the following conditions you may have had or have now **(- past + current):**

☐ Acid Reflux	☐ Allergy	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Difficult Breathing	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Kidney Problems	☐ Epilepsy	☐ Gall Bladder Problems
☐ Alcohol Use	☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure
☐ Irregular Periods	☐ Low/High Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐ Liver Problems	☐ Vaccines	☐ Neck Pain	☐ Nervousness	☐ Nerve Pain
☐ Pleurisy	☐ Pneumonia	☐ Ulcers	☐ Thyroid Problems	☐ Ringing in ears	☐Sinus Issues
☐ Stroke	☐ Tobacco Use	☐ Sleep Issues			

Other (please specify) _____

_____

_____

Surgeries with Dates: _____

_____

_____

Accidents/Sports Injuries: _____

_____

_____

History of head trauma? (describe)_____

_____

Medications/Supplements: _____

_____

_____

Family Health History: _____

_____

_____

Other health professionals you currently see and why: _____

_____

_____

I consent to a professional and complete wellness examination and to any radiographic examination that the doctor deems necessary. I also consent to receiving professional and complete wellness treatment for my current health concerns that the doctor deems necessary for my care. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. I authorize the release of any medical or other information necessary to process any applicable insurance claims. If insurance is being billed for my care, I further authorize the payment of medical benefits to the doctor(s) treating me at this facility.

Print Patient Name: _____ Date: _____

Signature: _____

Ohana Chiropractic and Wellness Center

Clinic Policies((please Initial each section)

_____ **Cancellation and Missed Appointments Policy:** Scheduled appointment times are reserved for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed for half the appointment rate. Exceptions can be made if you are sick or have an unavoidable emergency; in these cases, please contact the office as soon as possible to reschedule. Chiropractic only: your insurance company will not be billed for fees associated with missed or canceled appointments; therefore the payment will be your responsibility. **If you are or will be more than 10 minutes late, your appointment may need to be rescheduled.**

_____ **Insurance Notice:** Our clinic does NOT bill insurance for any NAET, Emotion Code, EVOX, or ZYTO health scan treatments. Upon request, we can provide patients with a superbill which can be used to submit your own claim to your insurance company. Many patients utilize their flex spending or Health Savings Accounts to get reimbursement.

_____ **Payment Policy:** Full payment is required at the time of service. Payment plans are available for patients with financial hardship. Our clinic also offers prepayment plans which discount the regular price per visit. Please note that checks that are denied for lack of funds will incur a fee of $35.00 per transaction. Please note, while we always strive to provide the best care possible, as with any healthcare provider, due to the complex nature of body and mind, we cannot guarantee any specific desired result.

Privacy Notice:

At Ohana Chiropractic & Wellness Center, we value your privacy; however, please be aware that we use an open treatment area. As such, it is possible that some discussion of your health condition(s) could be overheard by others. Your treatment could also be viewed by other patients. If at any time you prefer to discuss your health issues with your doctor privately, or if you prefer to be treated without being seen by other patients, please notify your doctor or the receptionist.

_____ **Medical Records:** In accordance with HIPAA Privacy Laws, I understand that I have the right to see or obtain a copy of my medical records. I also understand that Ohana Chiropractic has the right to require up to 30 days in which to organize and prepare the information. (Please note that if you wish to obtain a summary or copy of all your records, there may be a $30 documentation fee.)

_____ **Privacy:** By law, we must protect the privacy of your health information. We will not use or let other people see your health information without your permission. We will not tell anyone if you sought, are receiving, or have ever received services from us, unless the law allows us to disclose the information. We will ask you for written permission to use or disclose your health information.

If you would like to read the full edition of our Privacy Policy, we have copies available upon request.
I acknowledge that I have read and agree to all of the above conditions.

_____	_____	_____
Patient Name	Parent/Guardian Signature	Date Signed

Ohana Chiropractic and Wellness Center

N.A.E.T/ ASA Balance/AO Digital Body Analyzer Consent Form

I _____, certify that Ohana Chiropractic and Wellness Center and associated health providers do not claim to cure any illness or disease with NAET/ASA Balance/AO Digital Body Analyzer
_____ **Please initial that you have read this paragraph.**

I understand that NAET/ASA Balance/AO Digital Body Analyzer is not a medical diagnostic procedure and therefore does not diagnose a disease. NAET/ASA Balance/AO Digital Body Analyzer uses various, standard diagnostic measures and modalities to diagnose the patient's condition. NAET/ASA Balance/AO Digital Body Analyzer gives the practitioner an indication as to the substance(s) in which the patient may have sensitivity to and to which areas of the body may be out of balance. The premise behind NAET/ASA Balance/AO Digital Body Analyzer is to **desensitize** a patient to a substance(s) and balance the body overall through its own innate energy and abilities.
_____ **Please initial that you have read and understand this paragraph.**

I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who has prescribed them. During the 25 hours or after, if I have a life threatening reaction for the allergen for which I treated or from some other sources; I need to seek emergency medical assistance immediately, from a physician qualified in Emergency Medicine, a Hospital Emergency Room, or by calling 911. If I am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behavior, etc.) to keep my symptoms under control while I am treating with NAET/ASA Balance/AO Digital Body Analyzer. This will allow essential NAET/ASA Balance/AO Digital Body Analyzer treatments to be completed without interruption. _____ **Please initial that you have read this paragraph.**

I understand that for several hours after the treatment (hours will be set by practitioner) I am to avoid eating, touching, inhaling (smelling) or coming within five feet of the substance(s) that I have been desensitized for and/or treated. I realize that treatment may not work and I may have a sensitivity reaction. (This only applies with NAET treatments)
_____ **Please initial that you have read this paragraph.**

I fully understand that I may still experience some reaction to substance(s) of unknown severity, if I did not "clear" them completely and come in contact with them later. Therefore, I understand that it may require repeat procedures (additional office visits and NAET/ASA Balance/AO Digital Body Analyzer treatments at my expense) until I "clear" these allergens satisfactorily.
_____ **Please initial that you have read this paragraph.**

I have read or have had read to me the above information, and have had the opportunity to confer with my healthcare provider or a member of his staff about its contents. By signing below I agree to the terms or procedures.

_____ _____
Patient Name (Please Print) Date Signed

_____ _____Patient Signature
Parent or guardian signature (if patient is under 18years of age)

Ohana Chiropractic, Inc. 57 W. University Parkway
Orem, UT 84058 801-607-2599
www.ohanachiropractor.com

INFORMED CONSENT TO CHIROPRACTIC AND ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

Acupuncture

I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments, acupuncture, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment, acupuncture and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____ _____

Signature of Patient Date

_____ _____

Printed name of patient Date

_____

Signature of patient's representative (if minor)