Pinnacle Chiropractic & Wellness
10126 Brooks School Road, Fishers IN 46037
Phone: 317-288-4514 · Fax: 317-288-4517

Chiropractic Health History

Name: _____ Home Phone: _____

Address: _____City:_____State:_____Zip:_____

E-mail address: _____

Cell Phone number: _____

Cell phone provider for text reminders: AT&T Verizon Sprint T-Mobile Boost

Age: _____ Birth Date: _____ Marital: M S W D

Occupation: _____ Employer: _____

Phone: _____ Spouse:_____

How many children? _____ Ages of Children: _____

If Possible are you pregnant? _____

Emergency Contact Name: _____ Phone:_____

How were you referred to our office? _____

Family Medical Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? _____

Do you have Health Insurance □ Yes □ No

Is this visit to our office regarding: □ Chiropractic Care □ Nutritional Care □ Massage □ Any or all/as necessary

Are you here due to: □ Slip or Fall □ Vehicle Accident □ On the Job Injury □ Health Problem □ Wellness Care

1. What is the main reason you are seeking care?_____
2. When did the problem Start? _____
3. Have you had this problem before? □ Yes □ No If yes, when?_____
4. Is the problem (check all that apply): □ Constant □ Intermittent □ Numbness □ Pins and needles
   □ Dull ache □ Sharp Burning □ Radiating □ Localized □ Better in a.m. □ Better in p.m.
   □ Better while active □ Better while sitting □ Better while laying
5. Describe any other health problems:_____
6. Have you ever been to a Chiropractor? Yes No If yes, last visit_____
7. List surgeries and dates_____

Name: Printed (Parent sign for minor) _____
Please Sign_____ Date_____

PLEASE READ AND SIGN

1. I have been informed that a copy of Pinnacle Chiropractic & Wellness's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both in the office and on the website at www.pinnacleatgeist.com.

2. I consent to receive communication from Pinnacle Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

3. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable. Should the account be referred to an attorney or collections agency for collection, I understand that I am fully responsible for any collections fees, attorney's fees, interest, and any other expenses incurred in the collection of past due accounts.

4. I understand and agree that insurance policies are an arrangement between myself and the insurance company. I am personally responsible for any cost of care not paid for by the insurance policy. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to me. I agree it is my responsibility to understand my insurance coverage in relation to chiropractic care, and not the responsibility of Pinnacle Chiropractic.

5. I understand that the purpose of chiropractic care, nutritional and massage care is to improve my health and wellbeing. Chiropractic does not claim to be a cure for any condition but vertebral subluxation. Chiropractic, massage and nutritional care is not a replacement for medical care. Though our chiropractors will evaluate your condition and refer to the proper physician if necessary, he/she will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. As with any health care, there are some risks to receiving chiropractic care and/or massage therapy. These risks apply especially to elderly patients, those with a history of smoking, general poor health, and heavy medication usage. These risks include common issues such as muscular soreness or joint soreness, and more rare conditions such as fracture and vertebral artery dissection. If you have any questions about these rare adverse events please ask your doctor.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Kathleen Wiemold and Dr. Korey Wiemold permission to render chiropractic care and/or Katie Nord CMT permission to perform massage therapy.

Name: (Printed)_____

Signature _____ Date:_____

Thank you for trusting Pinnacle Chiropractic & Wellness