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: ____

Spouse:__________________

How many children? ___________ Ages of Children: ____

If Possible are you pregnant? ________________

Nearest Relative: ____________________ Address: ______________________________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**__________________________

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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. ❑ Yes ❑ No 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 agree that I am responsible for all bills incurred at this office. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

4. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. 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.

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 Rutan CMT permission to perform massage therapy.

Name: (Printed)____

Signature ____ Date:________________________

Thank you for trusting Pinnacle Chiropractic & Wellness