



Please tell us about yourself

Name (last) _____ (first) _____ (m.i.) _____

Home Address (street) _____

(city) _____ (state) _____ (zip) _____

Mobile Phone (_____) _____ Home (_____) _____

Birthdate _____ Ag _____ Email Addr _____

Would you like to receive emails about upcoming events at Hands of Hope ? Yes / No ☐ ☐

Employer _____ Occupation _____

Gender _____ Sex _____

Emergency Contact _____ Phone (_____) _____

Do you have a Health Savings Account (HSA) or Flex Spending Account (FSA)? _____

Previous Chiropractic: Yes/No If yes, date of last adjustment: _____

How did you find Hands of Hope? ☐ Google ☐ Facebook Referred by: _____ Other: _____

Reason for consulting Hands of Hope? _____

When did this begin _____ What makes it better or worse? _____

What is the current pain level on a scale of 1-10, with 1 being non-existent and 10 being severe? _____

Are you seeing other doctors or therapist for the above condition? _____

Please list any previous or current fractures, surgeries or hospitalization: _____

Please list any medications you are currently taking (prescription and non-prescription): _____

Are you pregnant or plan on getting pregnant? _____

What is your level of commitment to yourself, your health & your well-being: high / medium / Low _____

Are you or have you ever been in the military/ first responder / teacher? ☐ ☐ ☐

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, Craniosacral therapy and subtle energy re-balancing on me (or on the person named below for whom I am legally responsible) by JP Yurgel, D.C. or any doctors of chiropractic working or associated with or covering at Hands of Hope Chiropractic & Wellness Center.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, sprains, fractures, disc injury, stroke and dislocations. I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care and treatment involves the science, philosophy and art of locating and adjusting spinal interference patterns and misalignments and as such, is oriented toward improving spinal, neurological and muscular functions. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust joints and release muscles, which may cause an audible "click" or "pop" during the procedure.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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: Patient/ Parent/ Legal Representative (Attorney, Guardian, Parent)

Personal Health History (Confidential)

Name: _____ Date: _____

The body is designed to be healthy. Throughout life, events and experiences can occur which may have negatively affected your body's expression of health. The science of Chiropractic revolves around the detection and release of nerve interference and tension patterns stored in the spine and throughout the body called subluxations. Subluxations are caused by physical, chemical, mental and emotional stresses to which the body cannot adapt.

The following can contribute to the Vertebral Subluxation process. Please check any that apply

Physical Stress

Emotional / Mental Stress

Chemical Stress

☐ Birth Trauma

☐ Relationships

☐ Environmental

☐ Slip/Fall

☐ Career

☐ Smoker

☐ Car Accidents

☐ Family

☐ 2nd Hand Smoke

☐ Sports Injuries

☐ Financial

☐ Caffeine

☐ Physical Abuse

☐ Pace of Life

☐ Alcohol

☐ Heavy Physical Labor

☐ Quick Temper

☐ "Diet/Sugar-Free" Food

☐ Poor Posture

☐ Holding in Feelings

☐ Soda Intake

☐ Heavy Computer Use

☐ Perfectionism

☐ Prescription Drugs

☐ Repetitive Movements

☐ Procrastination

☐ Junk Food

☐ Prolonged Driving/Standing

☐ Depression

☐ Recreational drugs

What do you feel is the primary stress in your life?

What are the 5 healthiest habits you currently choose in your life?

In our office we are interested in your health and wellbeing and the health and wellbeing of your family and loved ones. Please mention any health conditions or concerns you may have about your -

Spouse/partner: _____

Children: _____

Parents (include significant medical history): _____

Siblings: _____

Financial Information: Who is responsible for this account with Hands of Hope Chiropractic & Wellness Center?

Dr.JP Yurgel, D.C. does not offer to diagnose or treat any symptom or disease condition. Our sole purpose is to analyze your system for Subluxation patterns and to help your body release them so it can more fully express its' innate ability to heal. Wellness is a dynamic equilibrium between health and disease. It exists when all organs of the body function at 100% under the direction of the nerve system and the Innate Intelligence of the body. If during your assessment a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider to serve you.

I, _____, have answered the above questions to the best **of my** knowledge. Based on the info _____, I give Dr. Yurgel, D.C. permission to assess, locate, and release my subluxation patterns.

Your Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Hands of Hope Chiropractic & Wellness Center (referred to as HOH from this point) Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for HOH to provide treatment to me, and necessary for HOH to obtain payment for that treatment and to carry out its health care operations. HOH explained to me that the Privacy Notice will be available to me in the future at my request. NPC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.
2. HOH reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following communications that will be used by HOH: a) telephoning and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me.
4. HOH may use and/or disclose my PHI in order for HOH to treat me and obtain payment for that treatment, and as necessary for HOH to conduct its specific health care operations.
5. I understand that I have a right to request that HOH restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, HOH is not required to agree to any restrictions that I have requested. If HOH agrees to requested restrictions, then the restriction is binding on HOH.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the HOH has already taken action in the reliance on this Consent.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, HOH will not treat me. I further understand that if I revoke this consent, at any time, HOH has the right to refuse to treat me.
8. HOH may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in HOHs practice.
9. I further understand this office utilizes an "open adjusting" environment for ongoing patient care. "Open adjusting" may involve several patients being seen in the same adjusting room at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients. This environment is used for ongoing care and is NOT the environment used for taking histories, providing examinations or presenting reports of findings (These are completed in a private confidential setting). If you choose not to be adjusted in an "open adjusting" environment, inform the doctor and arrangements will be made for you.

I acknowledge that I have received a copy of HOH's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

(Signature, Name, Title, Date, Representative of Patient, or Guardian, etc.)