

1 one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Name: _____

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Home Address: _____

CITY _____ STATE _____ ZIP _____

Home Phone #: _____

Other Phone #s: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY _____ STATE _____ ZIP _____

Occupation: _____ Work Phone#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

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INSURANCE INFO

Co. Name: _____

Address: _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, please explain: _____

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

3 three

PLEASE CONTINUE ON BACK

4 four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

- ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Have you ever had any of the following diseases/medical conditions(s)?

- | | | |
|--------------------------------|-------------------------------|-----------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV+ / Aids | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema /Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers / Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones / Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Do you smoke? ☐ No ☐ Yes / How Much? _____ How Long? _____

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? _____ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? _____ Nursing? ☐ Yes ☐ No

5 five

6 six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

S.S.#: _____

D.L.#: _____

Work Phone#: _____

Payment method:

- ☐ CASH ☐ Check ☐ Credit Card

CC# (if accepted)#: _____

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date ____ / ____ / ____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

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PAIN CHART

ABOUT YOU

Name: _____ File #: _____

Please describe your condition:

Signature: _____ Date: ____/____/____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort using the appropriate symbols.

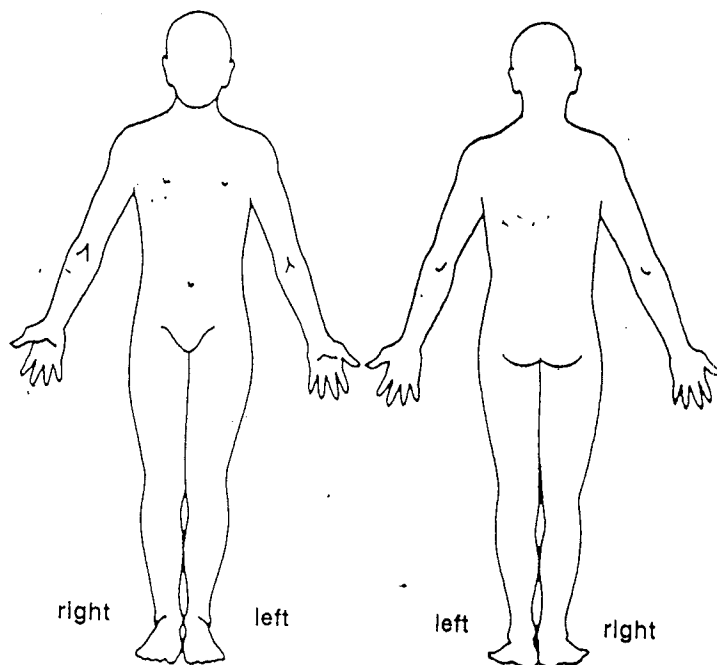
Numbness

Pins & Needles
OOOOO

Burning
AAAAA

Aching
XXXXX

Stabbing
●●●●●



Front

Back

DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____