chiropractic

remove obstacles • restore function • improve performance • maximize potential

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

_____
patient or guardian signature

_____
date

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Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT CONTACT

last name	first name	m.i.

preferred to be called

street

city	state	zip

home phone	mobile phone

work phone	e-mail

2 PATIENT PERSONAL

age	date of birth	social security #	sex	☐ male	☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone

relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.

employer name

work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation

street

city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date

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Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name | first name | m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ treatment for pain
- ☐ spinal and body alignment
- ☐ strengthening and stamina exercise
- ☐ patient education classes
- ☐ body composition counseling
- ☐ nutritional and supplement counseling
- ☐ other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
☐ no pain or discomfort	☐ slight discomfort	☐ pain that does not affect my activity	☐ pain that affects my daily activities	☐ pain that prevents performing my daily activities	☐ pain that limits my work schedule	☐ pain that prevents working at all	☐ pain that prevents working and all personal activity	☐ pain that keeps me bed ridden	☐ pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting

☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands

☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other_____

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
heart problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
kidney problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
cancer	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
headaches	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
back pain	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
obesity	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
poor conditioning	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism ☐ yes ☐ no	epilepsy ☐ yes ☐ no	low back pain ☐ yes ☐ no	polio ☐ yes ☐ no
anemia ☐ yes ☐ no	goiter ☐ yes ☐ no	measles ☐ yes ☐ no	rheumatic fever ☐ yes ☐ no
appendicitis ☐ yes ☐ no	heart disease ☐ yes ☐ no	mental disorder ☐ yes ☐ no	tuberculosis ☐ yes ☐ no
arthritis ☐ yes ☐ no	HIV positive ☐ yes ☐ no	mumps ☐ yes ☐ no	venereal infection ☐ yes ☐ no
cancer ☐ yes ☐ no	influenza ☐ yes ☐ no	pleurisy ☐ yes ☐ no	whiplash ☐ yes ☐ no
		pneumonia ☐ yes ☐ no	whooping cough ☐ yes ☐ no

6 INJURIES

patient name

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any job injuries that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any sports injuries that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any other injuries caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	rectal surgery	☐ yes ☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	sinus surgery	☐ yes ☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	hernia surgery	☐ yes ☐ no
back surgery	☐ yes	☐ no	_____			thyroid surgery	☐ yes ☐ no
						stomach surgery	☐ yes ☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐	consistent fainting	☐	chills	☐	convulsions	☐	depression	☐	dizziness
☐	loss of weight	☐	fatigue	☐	fever	☐	headache	☐	loss of sleep
☐	weight gain	☐	neuralgia	☐	night sweats	☐	wheezing	☐	nervousness

Gastro-Intestinal

☐	constipation	☐	diarrhea	☐	gall bladder problems	☐	hemorrhoids	☐	jaundice
☐	liver problems	☐	nausea	☐	stomach pain	☐	poor appetite	☐	poor digestion
☐	rectal bleeding	☐	vomiting	☐	vomiting blood				

Eye/Ear/Nose/Throat

☐	asthma	☐	crossed eyes	☐	deafness	☐	earache	☐	ear discharge
☐	ear noises	☐	enlarged thyroid	☐	frequent colds	☐	hay fever	☐	hoarseness
☐	nasal obstruction	☐	nose bleeds	☐	pain in eyes	☐	poor vision	☐	sinusitis
☐	sore throat	☐	tonsillitis						

Respiratory

☐	chest pain	☐	chronic cough	☐	difficulty breathing	☐	spitting blood	☐	spitting phlegm

Muscles/Joints/Bones

☐	backache	☐	foot problems	☐	pain bet. shoulders	☐	painful tailbone	☐	stiff neck
☐	spinal curvature	☐	swollen joints	☐	tremors	☐	twitching	☐	weakness

Cardio-Vascular

☐	ankle swelling	☐	high blood pressure	☐	low blood pressure	☐	heart trouble	☐	pain over heart
☐	poor circulation	☐	rapid heart	☐	slow heart	☐	strokes		

Skin or Allergies

☐	bruise easily	☐	dryness	☐	eczema	☐	hives	☐	itching
☐	sensitive skin								

Women

☐	cramps	☐	excessive flow	☐	hot flashes	☐	irregular cycle	☐	painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no On what date did your last period begin?

Do you want to take a pregnancy test now? ☐ yes ☐ no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	☐ yes ☐ no	complete or partial hysterectomy	☐ yes ☐ no	partner had a vasectomy	☐ yes ☐ no
less than 10 days since the start of my last period	☐ yes ☐ no	taking birth control pills	☐ yes ☐ no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or musole and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ **day of**_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:**_____

(please print) (please print)