

PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Date: _____

Patient: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Address: _____

Name of Spouse: _____ No. of Children _____ Names _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? Self Spouse Other _____

PATIENT'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

SPOUSE'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____

How did accident occur? Auto On the job Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? Yes No

If Yes, please describe? _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I hereby authorize the release of any and all patient information and medical records to the following person(s):

Patient Signature _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

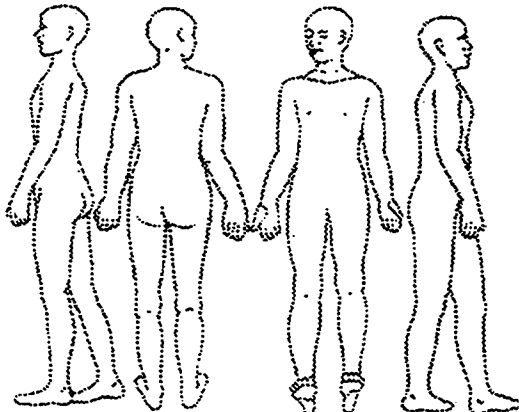
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



- P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

Informed Consent for Chiropractic Treatment

To the Patient: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to inform you so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other procedures, including various modes of physical therapies and diagnostic x-rays. The chiropractic treatment will be performed by the Doctor of Chiropractic working at this office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic in the office.

I have had the opportunity to discuss with the Doctor of Chiropractic in this office my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:
Broken bones, dislocations, sprains/strains, Worsening/aggravation of spinal conditions, increased symptoms and pain, no improvement of symptoms or pain, infection (acupuncture), or punctured lung (acupuncture).

In rare cases, there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative:

print name of patient

print name of patient's representative

signature of patient's representative

as: _____
relationship/authority of patient's representative

date signed

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Date