CONFIDENTIAL PATIENT INFORMATION

Name: _____ Marital Status (M S D W) Age: _____ Birth Date:_____/_____/_____

Height: _____ Weight: _____ Sex (F M) Race/Ethnicity: _____ Phone (H): _____(W):_____

Spouse's Name: _____Children: _____ SOCIAL SECURITY #**:** _____-____-_____

Street:_____ City: _____State:_____ Zip Code:_____

Email Address:_____ Cell #:_____ Medical Doctor_____

Permission to send reports to MD: Yes ☐ No ☐

Occupation: _____ How Long: _____ Employer: _____

How did you hear about our office: _____ Previous Chiropractic Care:_____

Operations/Surgeries (include date if available):

☐ Appendix	☐ Back	☐ Brain/Tumor	☐ Cervical Disc
☐ Chest	☐ Ears/Nose/Throat	☐ Elbow- Right / Left	☐ Foot- Right / Left
☐ Gallbladder	☐ Gastrointestinal	☐ Heart	☐ Heart Bypass
☐ Hernia	☐ Hip- Right / Left	☐ Hip Replace.-Right / Left	☐ Knee- Right / Left
☐ Knee Replace.- Right / Left	☐ Lumbar disc	☐ Neck	☐ Neurological
☐ Obstetrical	☐ Podiatric	☐ Shoulder- Right / Left	☐ Thoracic disc
☐ Wrist- Right / Left	☐ Other-		

Medical History-Please check if you have history of <u>or</u> Mark "BR" for blood relative:

☐ Ankle pain	☐ Arm pain	☐ Arthritis	☐ Asthma
☐ Back pain	☐ Broken bones	☐ Cancer	☐ Chest pain
☐ Depression/other disorders	☐ Diabetes	☐ Dizziness	☐ Elbow pain
☐ Epilepsy	☐ Eye/Vision Problems	☐ Fainting	☐ Fatigue
☐ Foot pain	☐ Genetic Spinal Disorder	☐ Hand pain	☐ Headaches
☐ Hearing Problems	☐ Hepatitis	☐ High Blood Pressure	☐ Hip pain
☐ Jaw pain	☐ Joint stiffness	☐ Knee pain	☐ Leg pain
☐ Low back pain	☐ Menstrual problems	☐ Mid back pain	☐ Minor heart trouble
☐ Multiple Sclerosis	☐ Neck pain	☐ Neurological Disorder	☐ Pacemaker
☐ Parkinson's Disease	☐ Polio	☐ Prostate problems	☐ Shoulder pain
☐ Significant weight change	☐ Spinal Cord injury	☐ Sprain/Strain	☐ Stroke/Heart Attack
☐ Stomach problems	☐ Tumor	☐ Ulcers	☐ Wrist pain

Symptoms not listed above: _____

What medications are you taking/reason for medication: _____

Allergies-Please check

☐ Animals	☐ Aspirin/Pain medications	☐ Bee Stings	☐ Chocolates/Sweets
☐ Dairy	☐ Dust	☐ Eggs	☐ Latex
☐ Molds	☐ Penicillin	☐ Ragweed/Pollen	☐ Rubber
☐ Seasonal Allergies	☐ Shellfish	☐ Soaps	☐ Wheat
☐ x-ray dye	☐ medications-	☐ other-	

Health Questions:

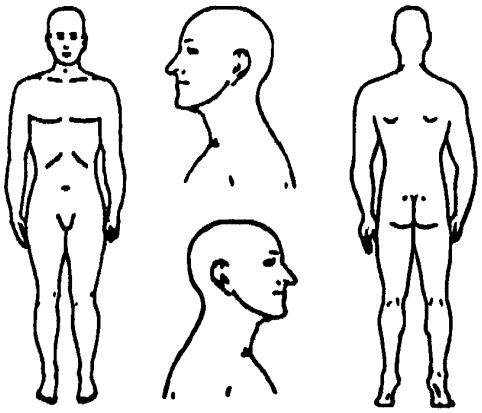
Do you smoke? _____ Drink alcoholic beverages? _____ Eat a well-balanced diet?_____

Sleep 6-8 hours? _____ Exercise Regularly?____ Preferred Language?_____

OFFICE USE ONLY

Blood Pressure	Pulse

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) □ Frequently (51-75% of the day)

Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **SECOND** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) □ Frequently (51-75% of the day)

Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your next complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

ACCIDENTS: Please describe, give date, injuries, broken bones, fractures, treatment

Automobile: _____

Occupational: _____

Recreational: _____

Childhood: _____

Other doctors seen for condition we are treating you for today: _____

X-Rays (date, where taken, of what, findings) _____

PLEASE LIST ANY AND ALL INSURANCE COVERAGE WHICH MAY BE APPLICABLE IN THIS CASE:

Primary Insurance Company: _____ Secondary Insurance Company: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient or Guardian's Signature: _____Date: _____

Thank you for choosing *DeWald Chiropractic*

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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 herby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

WITNESS:

_____ _____ _____

Printed Name Signature Date