



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home: \_\_\_\_\_ Email: \_\_\_\_\_

Would you like to receive text message reminders: Y N

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Marital Status: S M W D

Spouse Name: \_\_\_\_\_ Number of children: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who should we thank for referring you to our office? \_\_\_\_\_

### PURPOSE OF VISIT

Main reason for this visit- Chief complaint: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Did it begin: Gradually Suddenly

Type of pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

Is this related to an auto accident or work related injury? Yes No If yes, when \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

Is there anything that relieves your symptoms? Yes No Describe: \_\_\_\_\_

Does the pain radiate to your arms or legs? Yes No Is the condition getting worse? Yes No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does your complaint interfere with: \_\_\_ Work \_\_\_ Sleep \_\_\_ Hobbies \_\_\_ Daily Routine

Have you seen anyone else for this? Yes No If Yes, who: \_\_\_\_\_

What did they do? \_\_\_\_\_

Please list any other complaints:

1: \_\_\_\_\_ 3: \_\_\_\_\_

2: \_\_\_\_\_ 4: \_\_\_\_\_

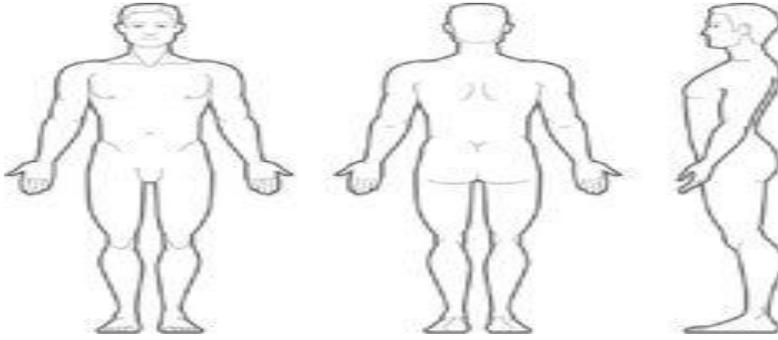
Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medication you are currently taking and their purpose: \_\_\_\_\_

Please list past surgeries and their year: \_\_\_\_\_

Please list any previous accidents and injuries: \_\_\_\_\_

AREAS OF COMPLAINT – Place “X’s” on the area (s) where you have pain and draw lines where it radiates:



### Cervical Spine (Neck)

Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and can cause the following problems, do you have any of these?

- |                                    |                                                              |                                              |
|------------------------------------|--------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Coldness in hands   |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness/tingling in arms/hands     | <input type="checkbox"/> Thyroid condition   |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hearing disturbances                | <input type="checkbox"/> Recurrent colds/flu |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Weakness in grip                    | <input type="checkbox"/> Low energy/fatigue  |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Visual Disturbances                 | <input type="checkbox"/> TMJ pain/clicking   |

### Thoracic Spine (Upper and Mid Back)

Subluxations in your upper and mid back weaken the nerves that go to your lungs, heart, ribs/chest, and upper digestive tract, do you have any of these?

- |                                             |                                               |                                                              |
|---------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Heart attacks/angina | <input type="checkbox"/> Recurrent lung infections           |
| <input type="checkbox"/> Heart murmurs      | <input type="checkbox"/> Asthma/wheezing      | <input type="checkbox"/> Pain on deep inspiration/expiration |
| <input type="checkbox"/> Tachycardia        | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Hypoglycemia                        |
| <input type="checkbox"/> Mid back pain      | <input type="checkbox"/> Reflux               | <input type="checkbox"/> Indigestion/heartburn               |
| <input type="checkbox"/> Rib/chest pain     | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Ulcers/Gastritis                    |

### Lumbar Spine (Low Back)

Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet, do you have any of these?

- |                                                        |                                                              |
|--------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness in your hips/knees/ankles  |
| <input type="checkbox"/> Low back pain                 | <input type="checkbox"/> Muscle Cramps in your legs/feet     |
| <input type="checkbox"/> Constipation/diarrhea         | <input type="checkbox"/> Numbness/tingling in your legs/feet |
| <input type="checkbox"/> Coldness in your legs/feet    | <input type="checkbox"/> Frequent/difficulty urinating       |
| <input type="checkbox"/> Cramps in your legs/feet      | <input type="checkbox"/> Menstrual irregularities/cramping   |
| <input type="checkbox"/> Sexual dysfunction            |                                                              |

### Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who? \_\_\_\_\_ When? \_\_\_\_\_

Reason for visit? \_\_\_\_\_

What treatments were given? \_\_\_\_\_

How did you respond? \_\_\_\_\_

Did your previous chiropractor take before and after x-rays? Yes No

Are you aware of any of your poor posture habits? Yes No Explain: \_\_\_\_\_

### Payment and Cancellation Policy:

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- We do not accept any major medical insurance. Payment for treatment can be rendered in the form of cash, check, credit card or health savings account.
- Should you not be able to be present for your appointment we require 24 hour advanced notice, failure to do so will incur a fee of \$20.00 per missed appointment.

By my signature below, I acknowledge that I have completed this intake and agree to the policies above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Date

Proceed to Consent for Treatment

And

HIPAA Notice of Privacy Practices



## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

### PATIENT INITIALS



**Chiropractic Care and Treatment.** I have and have had an opportunity to discuss with the chiropractic doctor, or other office or clinical personnel named below, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used by chiropractors including any necessary orthopedic, neurological, laboratory tests, imaging studies (X-rays, CT scans, MRIs, etc) and other procedures; chiropractic care and treatment protocols, including chiropractic adjustments, manipulation, mobilization and other therapies utilized by this office/practice in the care of my condition. Taken together, these procedures and protocols will be referred to as the office/practice's "chiropractic examination and treatment methods." Furthermore, it also has been communicated to me and I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed.

It also has been explained to me that if any tests were performed outside of this office/practice (e.g., laboratory or other diagnostic procedures), that the doctor or other staff member or clinician will notify me of the results at my next scheduled appointment.



**Nature of Chiropractic Treatment.** I have been informed that, on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feelings soreness or pain. During treatment, the doctor may use his or her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is often produced in some of the joint manipulation procedures and is caused by a separation of the smooth joint surfaces in much the same way a suction cup produces a popping sound when it is removed from glass or other smooth surface. Although a popping sound is not necessary, it is often a natural effect of joint movement.



**Permission for Physical Contact.** It has been explained to me, and I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas – such as during a procedure known as a "lumbar roll" where the doctor may contact with my rump (the posterior, superior spine of the Ilium) to adjust my sacroiliac joint, or some other similar or analogous procedure. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff member will explain to me ① what is to be done, ② how it will be performed, ③ why it will be performed, ④ that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, ⑤ that I will be given the opportunity to signal the doctor or clinician when I am ready to receive the test or procedure. I also agree that if I ever have any questions, doubts or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinical staff member. If for any reason I am reluctant to discuss these concerns directly with my doctor or clinician, or if I feel unsatisfied with the explanation given, I agree to seek a professional, third-party consultation from another licensed chiropractor mutually agreed upon by me and my chiropractor or clinician, or alternatively. The doctor, clinician and I agree to these stipulations to ensure that no misunderstandings or uncomfortable feelings arise as a result of physical contact between me and the doctor or other office/practice clinician. Finally, it is my understand that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited. After having the foregoing information explained to me I hereby request, consent and submit to the office/practice's chiropractic examination and treatment methods performed as explained to me.



**Risks of Chiropractic Care and Treatment.** I understand and have been informed that there is risk of side effects and complications anytime a doctor, provider or other clinician is asked to intervene in a healthcare encounter with a patient. I have been informed by the office/practice of the following: that although the risk of serious complication from chiropractic treatment is rare and unlikely, nonetheless, rare events ranging from relatively minor muscle soreness, aches, sprains and strains, to injuries to the spinal discs, nerves and cord, or an occasional fracture or dislocation in compromised patients with

certain concomitant diseases and illnesses have been reported in the scientific literature; that cerebrovascular accidents, such as a stroke, have also been reported; that these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in one-to-a-million to one-in-fortymillion cases of chiropractic, osteopathic, physical therapy and medical manipulation; about the same probability of stroke from turning your head or having your hair washed in a salon (“beauty parlor stroke’). In some of these instances, however, these dissections were not proximate in time or location to the treatment rendered, and consequently, it cannot be said with any certainty that the specific treatment caused the stroke, aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke.

It was explained to me and I do not expect the doctor to be able to anticipate all the potential risks or complications. Nor do I expect that the doctor or other clinician to provide me assurances that I will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his or her best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

It was explained to me that the most common and likely side effect of treatment will be muscular stiffness or soreness, described by some as akin to the ache people experience after exercising the first time in a long time; and that these effects are often transient and temporary. I was instructed that if I experience any increased discomfort following treatment, that I should apply ice to, and rest the affected area. I was also told that if I become concerned about any post-treatment discomfort or, I should develop of any new or unrelated symptoms. I also understand that if for some reason I am unable to reach or contact that doctor, that I should telephone my personal, primary care doctor or present myself to the nearest hospital emergency room.

**Consent.** By initialing each paragraph above in conjunction with the doctor, or other office or clinical personnel, acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning. By signing below I agree to submit to the above named chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from the office/practice indicated below.

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Patient's signature (or Parent/Guardian)

Date



**HIPAA Notice of Privacy Practices:**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. 1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare

Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or

Neglect: Food & Drug Administration requirements: Legal proceedings: Law

Enforcement: Coroners, Funeral Directors and Organ Donation: Research:

Criminal Activity: Military Activity and National Security: Worker's

Compensation: Inmates: Required Uses and Disclosures of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required uses and Disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: Following is a statement of your rights with respect to your protected health information You have the right to request a restriction of your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy

notes: information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state this specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14th 2003. 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. If you have any objections to this -form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 804-728-2837.

By my signature below, I acknowledge that I have read and agree to the above HIPAA Notice of Privacy Practices .

\_\_\_\_\_  
Patient's signature (or Parent/Guardian)

\_\_\_\_\_  
Date