Current Chiropractic Clinic

Date: ____/ _____/ _______

First Name: ______________________ Middle Initial: ________ Last Name: _______________________

Date of Birth: ____/ _____/ _______ Sex: ☐ Male ☐ Female

Social Security Number: _____ - ____ - __________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Race: ☐ **Caucasian** ☐ **African American** ☐ **Asian** ☐ **American Indian or AK Native** ☐ **Nat Hawaiian or Pac Islander**

Ethnicity: ☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino** ☐ **Other** ☐ **Decline**

Address Line 1: ____

Address Line 2: ____

City: _____________________________________ State: __________ Zip Code: _______________

Home Phone: (_____) ___________ Work Phone: (_____) ___________

Cell Phone: (_____) ___________ E-mail: _______________________________

Have you seen a Chiropractor in the past? _______ If Yes, When was your last visit? ____________

Name of Previous Chiropractor: _____________________________ Phone # ________________

May we request records from their office? __________

Name of Employer: ____

Employment Status: ☐ **Full-time** ☐ **Part-time** ☐ **Unemployed** ☐ **Retired** ☐ **Disabled**

Student Status: ☐ **FT Student** ☐ **PT Student**

Spouse:

First Name: ______________________ Middle Initial: ________ Last Name: _______________________

Phone: (_____) ___________ Date of Birth: ____/ _____/ _______

Emergency Contact:

Contact Name __________________________ Relationship to Patient ______________________

Contact Home Phone: (_____) ___________ Cell Phone: (_____) ___________

Patient Name: ______________________ Date ________
_

Payment/Insurance Information:

Will we be submitting insurance claims on your behalf? ☐ Yes ☐ No

☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ Worker's Comp ☐ Auto Accident Policy

Health Insurance Carrier/Carriers: ____________________________

Insurance Card ID # _______________________ **Group #** _________________________

Policy Holder's Name: ________________________________ **Employer:** ________________________________

Policy Holder's Date of Birth: ____/ _____/ _______ **Relation to Patient:** ______________________

HIPAA Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain Payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Current Chiropractic Clinic of our Notice of Privacy Practices. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand Current Chiropractic Clinic is not required to agree to my requested restrictions, but if Current Chiropractic Clinic does agree then they are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Current Chiropractic Clinic has taken action relying on this consent.

* *____________________________________ ____/ _____/ _______

Patient Signature: **Date:**

I authorize disclosure of information regarding billing, condition, treatment and prognosis to the following individual(s):

Name: ____ **Relationship:** _____________________

Name: ____ **Relationship:** _____________________

Name: ____ **Relationship:** _____________________

Consent to Treat a Minor: (Minor's Printed Name): ____

Guardian / Spouse's Signature Authorizing Care: ____

Date: ____/ _____/ _______

Patient Name: ______________________ **Date** ________

PERSONAL MEDICAL HISTORY

Smoking History: ☐ Current Smoker ☐ Former Smoker ☐ Never

Current: Weight _____________ Height _____________

Are you pregnant? ☐ Yes ☐ No Due Date _______________________

Pacemaker? ☐ Yes ☐ No If yes, when was it placed? ______________________

Past Surgeries (Please List): ____

Current Known Medical Conditions (Please List): ____

Current Medications (Please List): ____

____

Allergies to Medications? ☐ Yes ☐ No (If Yes, please list medications along with reactions):

____

____

Body Systems Check - (Circle your ***current*** problems):

Sleep - Problems falling asleep / Freq. waking / Early waking / Wake un-refreshed / Sleepy / Night sweats

General - General run down feeling / Frequent colds/flu / Nausea / Swelling/ Edema

Head - Headaches / Migraines / Panic attacks / Scalp Issues / Hair loss

Eyes - Blurred vision / Itchiness / Spots / Dryness/ Glaucoma / Photosensitivity

Ears - Hearing difficulty / Infections / Itchy ears / Sound sensitivity / Wax build up

Sinuses - Sinusitis / Congestion / Dripping / Phlegm / Allergies

Lungs/Heart - Breathing Difficulty / Infections / Palpitations / Chest pain / Angina / Arrhythmias / Blood pressure

Muscle & Joints - Pain / Inflammation / Back/neck/shoulder aches / Lack of mobility / Muscle weakness

Nerves - Pain / Burning / Numbness / Tingling / Sensitivity

Bladder - Pain / Frequent night visits to toilet / Infections / Stress incontinence

Digestion - Abdominal pain / Gastric reflux / Difficulty swallowing / Food cravings

Skin - Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot / Moles / Weak nails

Patient Name: ______________________ Date ________

Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

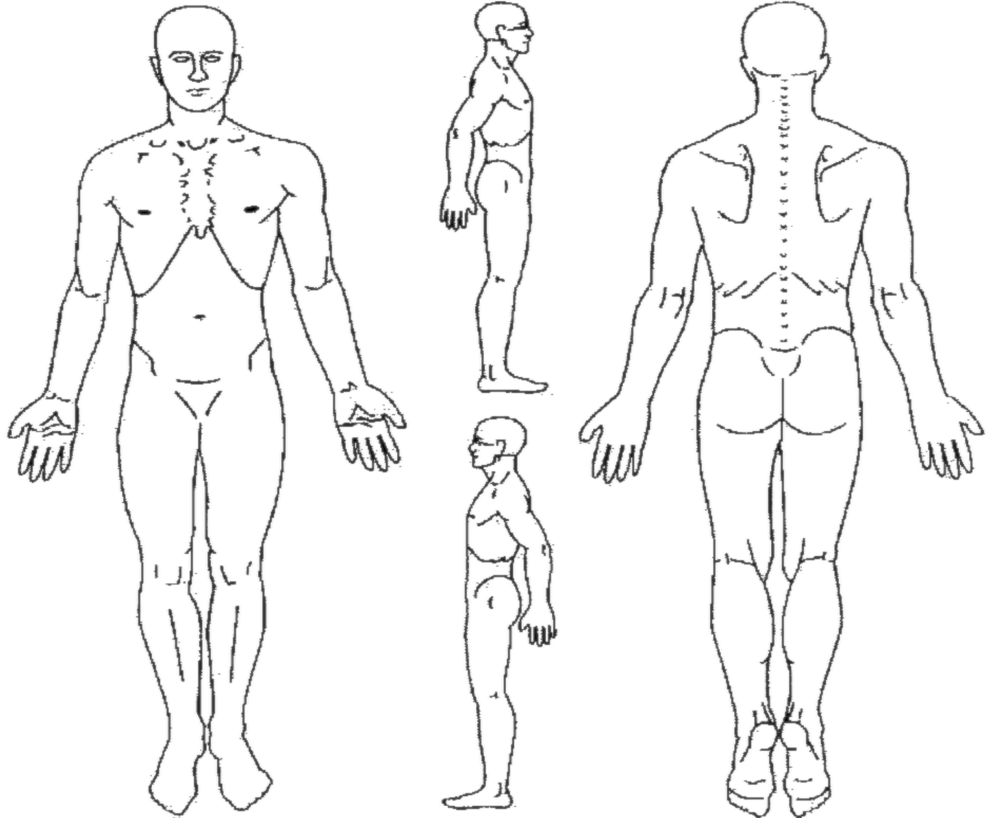
N= Numbness

B= Burning

S= Stabbing

T= Tingling

A= Dull Ache



Describe your symptoms in order of severity, with worst symptom being #1:

____

____

____

Are your symptoms a result of:

☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other ____________

When did your symptoms begin? Month _______ Day _______ Year _______

How did your symptoms begin? ____

____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other ______________

Patient Name: ______________________ Date ________

INFORMED CONSENT FORM

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

_ spinal manipulative therapy
_ palpation
_ vital signs
_ range of motion testing
_ orthopedic testing
_ basic neurological testing
_ muscle strength testing
_ postural analysis
_ultrasound
_ hot/cold therapy
_Electrical Stim
_ radiographic studies
_mechanical traction
_ Other (please explain) ____

____

____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (Dr. Cameron Current) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ____/ _____/ _______

____

Patient's Name:

____

Signature:

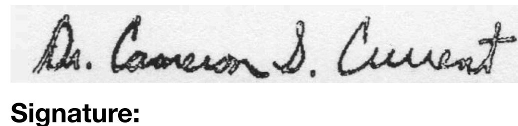
____

Signature of Parent or Guardian
(if a minor)

Dated: ____/ _____/ _______

Dr. Cameron Current

Doctor's Name



Signature: