LIBERTY CHIROPRACTIC

Patient's Name _____

Date: _____

What is the reason for you visit today?

_____

Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Slip and Fall □ Other

Personal Information

Address_____ City/State/Zip_____

Phone #_____ (home) _____ (cell)

E-mail_____ SS#_____

Birth Date _____ Age _____

Height _____ Weight _____ □ Male □ Female

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Pacific Islander □ White □ Other □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Preferred Language: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's name (if applicable) _____

Emergency Contact: Name _____ Relationship: _____

Phone # (s) _____

Primary Care Doctor (name, address, phone number)

_____

How did you hear about our office? _____

CHIROPRACTIC HISTORY

Have you ever seen a chiropractor before? □ No □ Yes If yes, how long ago? _____

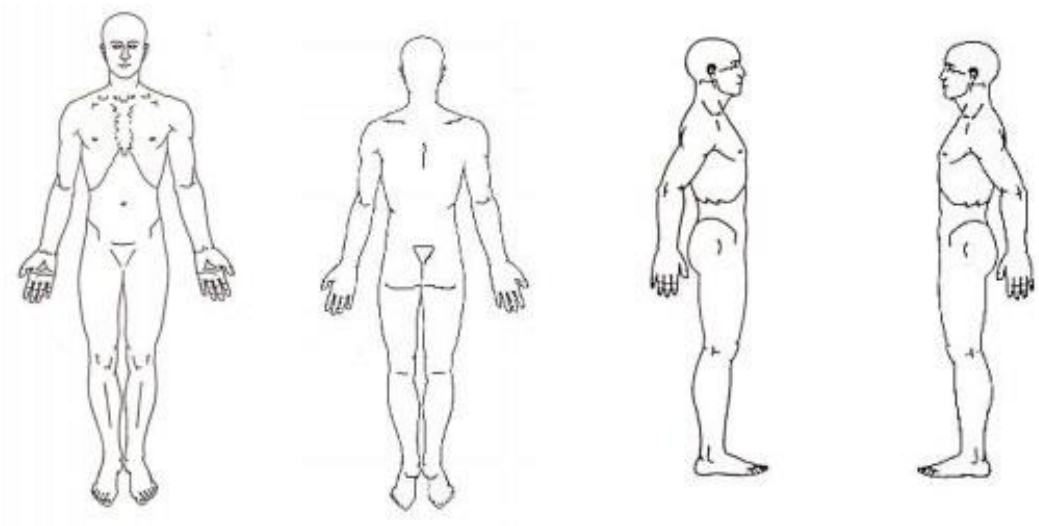
CHIEF COMPLAINT

On the Scale below, rate the pain intensity by circling the appropriate number.

0 = no pain, 10 = unbearable pain

0	1	2	3	4	5	6	7	8	9	10

Indicate on the drawings below where you have pain/symptoms:



How often do you experience the 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)

Comments: _____

How would you describe the type of pain?

□ Sharp □ Numb □ Achy □ Burning □ Sharp with motion

□ Dull □ Tingling □ Diffuse □ Shooting □ Shooting with motion

□ Stiff □ Electric like □ Stabbing with motion

□ Other _____

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □Getting Better

How long have you had this problem? _____

How do you think your problem began? _____

What activities make the pain worse? _____

What activities reduce the pain? _____

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician

□ Orthopedist □ Physical Therapist □ Other: _____ □ No one

ACTIVITIES

What activities do you do at work?

_____

What activities do you do outside of work?

_____

What type of exercise do you do on a regular basis?

□ Strenuous □ Moderate □ Light □ None

FAMILY

Indicate if you have some immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems

□ Cancer □ ALS □ Stroke □ Other _____

MEDICAL HISTORY

Please indicate if you have had any of the conditions listed below:

□ Headaches □ Loss of Bladder Control □ Kidney problems/disease □ Diabetes

□ High Blood Pressure □ Heart Problems/Disease □ Stroke □ High Cholesterol

□ Cancer □ Depression □ Allergies □ Abnormal Weight gain/loss

□ Drug/Alcohol Dependence □ Arthritis □ Dizziness □ General fatigue

□ Other _____

Smoking Status *(please circle):*

Never Smoked	Former Smoker	Current Every Day Smoker	Current Some Day Smoker
	Current Light Smoker	Current Heavy Smoker	

List all prescription and over the counter medications you are currently taking along with any supplements:

Name of Medication	Strength: i.e. 10 mg	Instructions: i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: □

Name of Drug*: i.e. penicillin*	Symptom: *i.e. headaches*

List all surgical procedures you have had:

_____

_____

List any diagnostic tests you've had (i.e. x-rays, MRI, etc.)

_____

Have you ever been hospitalized or had significant past trauma? □ Yes □ No

If yes, explain:

_____

_____

** Standard Assignment and Release **

I assign and authorize my insurance benefits to be paid directly to Liberty Chiropractic. I understand that I am financially responsible for any balance incurred for services rendered, except in the case of worker's compensation and contractual write-offs. I waive any statutory time limitations for collecting any amount due and authorize Liberty Chiropractic to release any information necessary to process my claims.

_____ _____

Signature of Insured/Guardian Date

Informed Consent for Chiropractic Treatment

All medical procedures have potential side effects and complications. While the risk of serious complication resulting from the procedures utilized in this office is extremely small, we feel it is important for you to be fully informed prior to proceeding with our care.

Prior to any treatment being provided in this office a physical examination will be undertaken in which your body will be moved in different directions to determine where the pain is coming from. This can result in residual pain or soreness.

The primary treatments used by the chiropractic physicians in this office are various types of manual techniques (manipulation, mobilization) and various types of exercise. In approximately 1/3 of patients who are treated with manipulation, increased pain results, usually after the first or second treatment. This is mild or moderate in 90% of cases and almost always resolves within 48 hours. In rare cases, rib fractures have been known to occur. No treatment will be provided until an examination is performed, a diagnosis is made and a discussion of our findings and recommendations is undertaken.

There are rare reported cases of disc injuries identified following manipulation, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by manipulation. However, there are uncommon cases in which a pre-existing disc herniation may become aggravated.

There are reported cases of stroke associated with visits to both medical physicians and chiropractic physicians. Research and scientific evidence does not establish a cause and effect relationship between manipulation 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 manipulation is extremely remote.

Other treatment options outside this office may include, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, injections and 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.

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.

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.

_____

Patient’s Signature

PATIENT CONSENT FORM

(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

--Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
--Obtaining payment from third party payers (e.g. my insurance company)
--The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Signature: _____