Sundby Family Chiropractic

## GENERAL INFORMATION

Patient Name:______________________________

Address:______________________________

City:______________________________

State:______________ Zip:______________________

e-mail:______________________________

Phone:__________________ ☐ Cell ☐ Home

Date of Birth:______________________________

Occupation:______________________________

Employer:______________________________

How did you hear about/find us?______________

______________________________

Is this your first visit to a Dr. of Chiropractic?

☐ No ☐ Yes

**Emergency Contact Info**

Name:______________________________

Relationship:______________________________

Phone:__________________ ☐ Cell ☐ Home

**INSURANCE:**

Health Insurance Co. Name______________________

Policy Number ______________________________

Policy Holder's Name______________________

Policy Holder's Social Security #__________________

**DOCTORS NOTES:**

## REASON FOR VISIT

What brings you in today?______________________

______________________________

Have you received treatment for this condition in the past? ☐ No ☐ Yes

If yes, where?______________________________

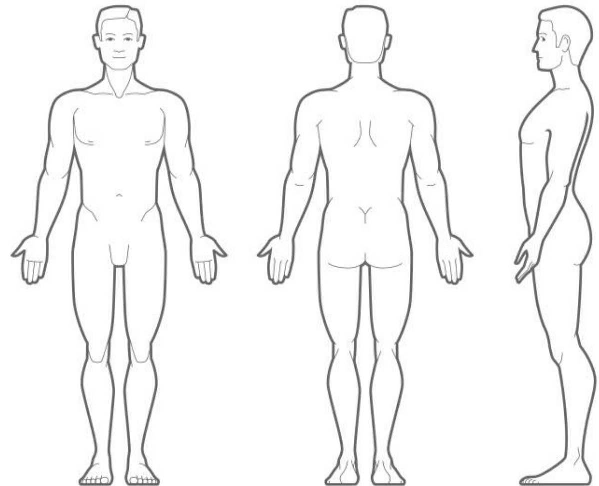
When?______________________________

Are you seeking treatment related to an accident?

☐ Auto ☐ Work ☐ Other ☐ No

Using the symbols below, please mark any areas where you're experiencing:

× Pain ⊘ Numbness or Tingling # Burning



How severe is your pain on a scale of 0 to 10:

On Average?______ At worst?_______ At best?______

Check the boxes that best describe your symptoms:

☐ Constant ☐ Comes & goes ☐ Worse at night

☐ Worse in the morning ☐ Sharp ☐ Dull

☐ Aching ☐ Shooting ☐ Throbbing

When did your symptoms first appear?______________

______________________________

What (if anything) makes it better?______________

______________________________

What makes it worse or irritates it?______________

______________________________

# HEALTH HISTORY

**Recent signs & symptoms:** (Please check all that apply.)

- ☐ Constant Pain
- ☐ Unexplained Weight Loss/Gain
- ☐ Loss of Bladder Control
- ☐ Abnormal Bleeding
- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Frequent/Painful Urination
- ☐ Excessive Bruising
- ☐ Fever, Chills, Sweats
- ☐ Nausea/Vomiting
- ☐ Blood in Urine
- ☐ Difficulty Breathing
- ☐ Change in Appetite
- ☐ Severe Abdominal Pain
- ☐ Black/Bloody Stools
- ☐ Tightness/Pain in Chest

Are you currently pregnant? ☐ No ☐ Yes, Due Date: ____________

**Have you ever had any of the following conditions?**

- ☐ Cancer
- ☐ Hypertension
- ☐ Recurring Sinusitis
- ☐ Disc Herniation/Bulge
- ☐ Anemia
- ☐ Pacemaker
- ☐ Bloating
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Stroke
- ☐ Belching/Gas
- ☐ Osteoporosis
- ☐ Bruise Easily
- ☐ Swelling in Ankles/Legs
- ☐ Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Clotting Disorder
- ☐ Allergies
- ☐ Anxiety
- ☐ Latex Allergy
- ☐ Cardiovascular Disease
- ☐ Glaucoma
- ☐ Depression
- ☐ Psoriasis
- ☐ Heart Attack
- ☐ Recurring Ear Infections
- ☐ Drug/Alcohol Dependency
- ☐ Sprained Ankle

**Please list any injuries, hospitalizations or surgeries, with approximate dates:** (broken bones, appendicitis, etc…)

| MEDICATIONS | VITAMINS | ALLERGIES |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

**DOCTOR'S NOTES**

# LIFESTYLE

**Exercise**

- ☐ None
- ☐ Minimal
- ☐ Moderate
- ☐ Daily
- ☐ Excessive

**Work Activity**

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Medium Labor
- ☐ Heavy Labor

**Habits**

- ☐ Smoking Frequency: ____________________
- ☐ Alcohol Frequency: ____________________
- ☐ Recreational Drugs Type: ____________________
- ☐ Coffee/Caffeine Frequency: ____________________
- ☐ High Stress Reason: ____________________

**Nutrition**

How would you describe your eating habits?

- ☐ I eat whatever and whenever I want.
- ☐ I make an attempt to eat right, but struggle.
- ☐ Most of the time I eat right, but treat myself on occasion.
- ☐ I strictly regulate my food intake, all the time.
- ☐ I'm all over the board. No consistency

**DOCTOR'S NOTES**

**Sleep**

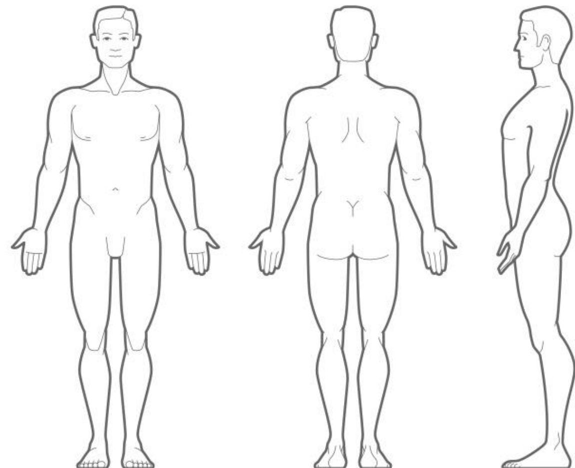
Average hours of sleep per night?________________________

I normally sleep on my:

☐ Back ☐ Stomach ☐ Side ☐ Toss & Turn

# SCAR TISSUE

Using the diagram below, please indicate where you have any significant scars, past muscle tears or surgical scars.



# PAYMENT POLICY

Payment for services rendered will be due on the date of service and accepted in the forms of check or charge. I may choose to submit a reimbursement claim directly to my insurance provider. Sundby Family Chiropractic will supply any additional documentation regarding my treatment, needed for this purpose, at my written request.

Please initial to accept this policy ____________

## Authorization to Release Information

______ I authorize Sundby Family Chiropractic to release all information related to the care I receive, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

## Information about possible Risks of Treatment

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headaches and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be preformed to help identify if you may be susceptible to this type of injury, you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, or physiotherapy burns. These are extremely rare occurrences.

## Consent for Treatment

______ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by my Doctor of Chiropractic or other personnel involved in my care.

## Assignment of Benefits

______ I assign Sundby Family Chiropractic all benefits payable to me for my care. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

## Guarantee of Payment

______ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

| ______________________ | ______________ | ______________________ |
|---|---|---|
| Signature of Patient/Guardian | Date | Relationship to Patient |

| ______________________ | ______________________ |
|---|---|
| Reason Patient is Unable to Sign | Witness |

# 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 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 procedure concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Sundby Chiropractic to use their 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 to 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 affect 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 these 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 healthcare operations, the chiropractic physician has the right to refuse to give care.
8. The patient allows us to contact them by mail or by phone for scheduling purposes or educational mailings.
9. The patient allows us to print their first name and last initial in our office newsletter, testimonial, referral board, etc.

***I have read and understand how my PHI will be used and I agree to these policies and procedures.***

______________________________ ______________________

***Signature*** ***Date***