E320 Chiropractic

Patient Health History

Name: _____ Age: _____ **Birth Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____

Cell Phone #: _____ **Cell Phone Carrier:** _____

How did you hear about our office? _____

Gender: _____ **Marital Status:** _____ **# of Children**: _____

Occupation: _____ **Employer:** _____

Height: _____ **Weight:** _____ **How would you describe your diet?** _____

Social History

Habits:

Smoking:	□No	□Yes	Packs per Day: _____	# of Years: _____
Alcohol:	□No	□Yes	Type: _____	Frequency: _____
Caffeine:	□No	□Yes	Type: _____	Frequency: _____

Exercise:

□ None □ 1-2 days □ 3-4 days □5-6 days □Everyday

Preferred form(s) of exercise: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

□ Appendicitis	□ Anemia	□ Heart Attack	□ Arthritis
□ Pneumonia	□ Measles	□ Cancer	□ Epilepsy
□ Rheumatic Fever	□Mumps	□ Goiter	□ Mental Disorder
□ Polio	□ Chicken Pox	□ Pleurisy	□ Addiction
□ Tuberculosis	□ Shingles	□ Gout	□ Eating Disorder
□ Whooping Cough	□ Diabetes	□ Stroke	□ HIV

OPERATION & PROCEDURES

** **Please include date of operation/procedure**

□ Stomach _____	□ Tonsillectomy _____	□ Gall Bladder_____	□ Back Surgery____
□ Tubes in Ears _____	□ Appendectomy _____	□ Female Organs _____	□ Rectal Surgery___
□ Sinus _____	□ Hernia _____	□ Thyroid_____	□ Other: _____

GENERAL SYMPTOMS
□ Allergy (What?)_____
□ Dizziness
□ Fatigue
□ Headaches
□ Loss of Sleep
□ Night Sweats
□ Weight Loss

CARDIOVASCULAR
□ Poor Circulation
□ High Blood Pressure
□ Low Blood Pressure
□ Pain over Heart

Digestion
□ Celiac Disease
□ Crohn's Disease
□ Irritable Bowel Syndrome
□ Constipation
□ Diarrhea
□ Frequent Urination
□ Inability to Control Urine
□ Painful Urination
□ Excessive Thirst

RESPIRATORY
□ Chest Pain
□ Chronic Cough/mucous
□ Difficulty Breathing
□ Coughing Up Blood

FOR WOMEN ONLY
□ Menstrual Cramps
□ Hot Flashes
□ Irregular Cycle
□ Miscarriage
□ Pregnant
□ In Vitro Fertilization
Last Pap: _____
Last Breast Exam: _____

Family History

**** Check all that apply****

Mother: □Diabetes □Heart Disease □Cancer: (type) _____ □Back Issues □Other _____

Father: □Diabetes □Heart Disease □Cancer: (type) _____ □Back Issues □Other _____

Brother: □Diabetes □Heart Disease □Cancer: (type) _____ □Back Issues □Other _____

Sister: □Diabetes □Heart Disease □Cancer: (type) _____ □Back Issues □Other _____

Chief Complaint:

Location of Pain:_____ Duration**: (how long?)** _____

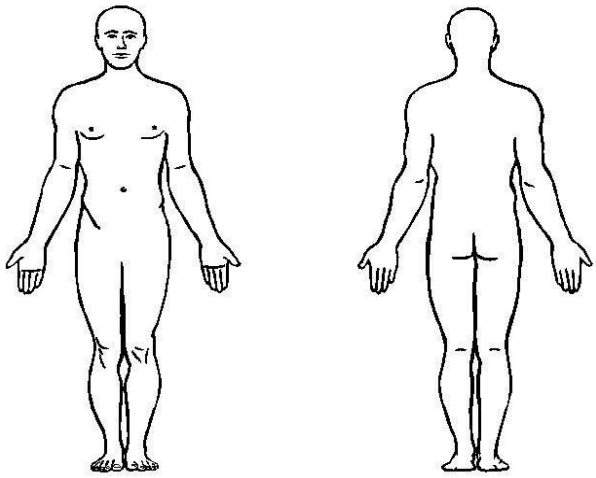
What brought on the Pain? _____

Describe the Pain: _____

Rate the Pain: 1-10 (10=worst pain ever) _____

What makes it Better? _____

What makes it Worse? _____



Does the Pain travel to another area of the body? □ No □ Yes - Where? _____

Is there a time of day where the pain is more noticeable? _____

Are there any tasks (yard work, house cleaning, personal grooming) that you are not able to do because of the Pain? _____

Accidents/Falls/Past Injuries

1. List any incidents; please include the dates.

□ Car Accidents _____

□ Recreational Vehicle Accidents _____

□ Sports Injuries _____

□ Work Injuries/Falls _____

□ Other _____

2. List any broken bones, fractures or dislocations: _____
Date (s):_____

3. Ever on crutches? □ No □ Yes Why? _____

4. Have you ever had a spinal tap/ spinal injection? □ No □Yes - Why? _____

5. Were you ever knocked unconscious (concussions)? □ No □ Yes- Explain _____

6. Have you ever had a lapse in memory? □No □Yes – Explain _____

7. Have you ever had X-Rays taken? □No □Yes - When where the x-rays taken? _____

Who took the X-Rays? _____ Why were X-Rays taken? _____

8. Do you suffer from any condition other than that for which you are now consulting us? □No □Yes

9. Are you presently taking any medication- prescriptions/over the counter? □No □Yes

Medications	Dose	Times per Day	Reason for Taking

I understand and agree that the accident and health insurance policies are an arrangement between an insurance carrier and myself. I understand that E320 Chiropractic LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered are charged to me directly and that I am personally responsible for all charges at the time of service.

Patient/Guardian Signature: _____ Date: _____

Patient Informed Consent

Patient Name: _____

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

The Nature of the Chiropractic Adjustment: The primary treatment used by doctors 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 (Static, Muscle & Motion)
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic neurological
- Muscle Strength Testing
- Postural Analysis Testing
- Ultrasound
- Hot/Cold therapy
- Electrical Muscle Stimulation
- Radiographic (X-Rays) Studies – these will be referred out to another facility

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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history, during examination and x-rays (when needed). Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

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.

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. Rhonda K. Lisowe DC or a staff member of E320 Chiropractic LLC 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.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature (if a Minor): _____

HIPAA - Health Insurance Portability and Accountability Act
Notice of Privacy Policy

E320 Chiropractic LLC
2702 N. Main St. STE C
Anderson, SC 29621
Phone: 864.367.6766

The following is an explanation of our Privacy Policy and your rights as a patient.

□ Our office does not distribute or make available to any outside source your "protected health information," or (PHI).

□ Your personal health information is secure and used only for treatment, claims submission to third party insurance carriers for the purposes of payment, and other health care operations.

□ A family member may be present when taking a case history, hearing the results of exams or tests, or during normal office visits. Family or friends will only have access to your PHI with your written authorization.

□ Our office may send you seasonal, birthday, or reminder cards to the address supplied on your intake forms.

□ Our office may call/text/email you to confirm or reschedule an appointment. We may leave a message on the answering machine unless you have specifically instructed us to the contrary.

□ You have the right to withdraw consent and terminate care at any time for any reason. A withdrawal of consent must be made in writing.

□ You have the right to ask questions about the status of your health at any time.

□ You have the right to view and copy your own file. Copying and mailing charges may apply.

By my signature below, I acknowledge that I have read, understand, and agree with the privacy policies set forth by E320 Chiropractic LLC. At my request, I am entitled to view and keep a copy of this abbreviated form or the corresponding full privacy statement, which is also made available on the practice's website: www.E320Chiropractic.com

Patient Signature _____ Date: _____

Printed Name: _____