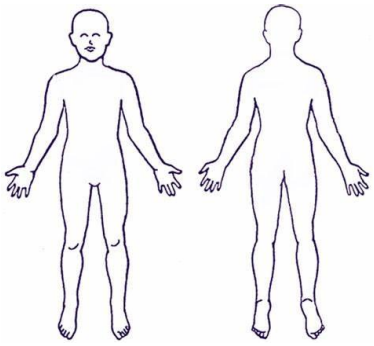
Patient Form

Patient Name:_____ **Birthdate:** _____ **Sex: M / F**
Address:_____ **City:** _____ **State:** _____ **Zip:**_____
Telephone:_____**Work Phone:** _____ **Email:**_____
Social Security #: _____
Circle Payment Plan: Insurance or Cash
Have you ever been treated by another Chiropractor?
☐**YES**☐**NO If yes, when and why?** _____
_____

IS THIS? ☐**WORK RELATED**☐**AUTO RELATED**☐**N/A**
Date problem began:_____

Describe your current problem and how it began:
_____
_____
How you found out about us or who referred you:
_____

Mark an X on the picture where you have pain or other symptoms



Current Complaint: (how you feel today)

1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE PAIN

HOW OFTEN ARE YOUR SYMPTOMS PRESENT?

☐**0-25%**☐**26-50%**☐**51-75%**☐**76-100%**

CAN YOU PERFORM YOUR DAILY ACTIVITIES? ☐**YES**☐**NO (DESCRIBE):** _____
_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?☐**YES**☐**NO DATE(S) TAKEN:**_____
WHAT AREAS WERE TAKEN? _____

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU: ☐**NONE APPLY**

YES/NO	CONDITION	YES/NO	CONDITION	YES/NO	CONDITION
☐☐	Recent Trauma	☐☐	Blurry Vision	☐☐	History of Low/Mid Back Pain
☐☐	Loss of balance	☐☐	History of Blood Clot	☐☐	History of Neck Pain
☐☐	Dizziness/Fainting	☐☐	Nausea	☐☐	History of Alcohol Use
☐☐	Diabetes	☐☐	Ringing in the Ears	☐☐	History of Tobacco Use
☐☐	Corticosteroid Use	☐☐	Epilepsy/Seizures	☐☐	Aortic Aneurysm
☐☐	Birth Control Pills	☐☐	Prostate Problems	☐☐	Cancer/Tumor
☐☐	High Blood Pressure	☐☐	Urination Problems	☐☐	Muscle Pain/Cramps
☐☐	Headaches	☐☐	Osteoporosis	☐☐	Muscle Weakness
☐☐	Visual Disturbances	☐☐	Pregnancy, # of Births _____	Other: _____	
☐☐	Stroke (date) _____	☐☐	Abnormal Weight☐Gain☐Loss _____		

FAMILY HISTORY:☐**Cancer** ☐**Diabetes** ☐**High Blood Pressure** ☐**Cardiovascular Problems/Stroke**

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. Therefore I give authorization to my chiropractor to contact another physician, if necessary.

PATIENT SIGNATURE:_____ **Date:** _____

INTIAL EACH LINE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

_____ Medical doctors, chiropractic doctors, osteopaths, and physical therapist who perform manipulations are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/ adjustments involving movement of the joints and soft tissues. Physical therapy and exercise may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

_____ ***Soreness***: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

_____ ***Dizziness:*** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

_____ ***Fracture/Joint Injury:*** I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

_____ ***Stroke:*** Although strokes happen with some frequency in our world, strokes from chiropractic adjustment are rare. I am aware that nerve or brain damage including stroke is reported to occur in one million to once in ten million treatments.

_____ ***Physical Therapy Burns:*** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

_____ Tests have been performed on me to minimize the risk of complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

_____ I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the counter medications, exercise and possible surgery.

_____ ***Medications:*** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Some medications may involve serious risks.

_____ ***Rest/Exercise:*** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

_____ ***Surgery:*** Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

_____ ***Nontreatment:*** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction prior to my signing these consent form. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:

_____

Date: _____

Wolfrum Crossing Chiropractic
1043A Wolfrum Road
Weldon Spring, MO. 63304

HIPPA CONSENT FORM

_____hereby states that by signing this consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice has been provided to me prior to my signing this Consent. the Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the above address provided by me: and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by email.

4. The Practice may use and/or disclose my PHI (which includes info. about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have the right to request the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at anytime for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if i revoke this consent at any time the Practice has the right to refuse to treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way I can understand.

_____ _____

Name of Patient/Individual (please print) Signature of Patient/Individual/Date signed