

Patient information (please complete using your name as listed on your insurance card):

Name: _____ Date Of Birth: _____ Today's Date: _____

Address: _____

Street City State Zip code

Home Phone: () _____ Work Phone () _____ Cell Phone () _____

Cell Phone Carrier for text Reminders: _____

Social Security #: _____ Male Female

Occupation _____ Single Married Divorced Widowed

Email Address: _____

Insurance Co. _____ ID#: _____

Who may we thank for referring you to us? _____

Patient Signature: _____

PATIENT HEALTH ASSESSMENT

1. What is your present complaint?

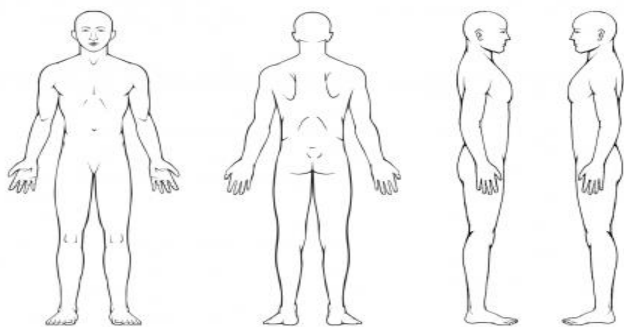
2. How would you describe your pain:

- Sharp Soreness Throbbing Tingling
- Dull Stiffness Spasm Burning
- Ache Weakness Numbness Shooting

3. How would you rate the intensity of your pain? (Please circle)

0 1 2 3 4 5 6 7 8 9 10
(no pain) _____ (terrible/unbearable pain)

4. Please mark on the body below where you feel your pain:



5. How often is the pain present?

- Constant (80-100%) Frequent (50-80%) Occasional (25-50%) Intermittent (25% or less)

6. When did your problem begin? (Give an approx. date if possible) _____

7. Since your problem began is the pain:

- Getting worse Getting better Staying the same

8. How did your problem begin?

- An Auto Accident Work related accident Other type of accident
- Gradual Sudden No specific reason

9. Describe how the problem began. _____

10. What makes your problem better?

- Nothing Walking Standing Sitting
- Moving around/exercise Lying Down Inactivity

11. What makes your problem worse?

- Nothing Walking Standing Sitting
- Moving around/exercise Lying Down Inactivity

12. What prior treatments have you received for this present condition?

- Medical Surgical Physical Therapy Acupuncture Other: _____

13. Have you had this problem in the past? Yes No

If yes, please explain: _____

14. Were you previously treated for an earlier occurrence of this same condition?

- Yes No

If yes, by whom? MD Chiropractor Physical Therapist Other

What were the approximate dates, type of treatment and the results? _____

15. Are you currently taking any medications? Yes No

if yes, please describe: _____

16. Do you have any allergies?

if yes, please describe: _____

17. What is your physical activity at work?

- Mostly sitting Light manual labor
- Moderate manual labor Heavy manual labor

18. What general physical activity do you do include exercise.

- Mostly sitting Light activity Moderate activity Heavy activity

Describe _____

19. What is your present general stress level?

- No stress Minimal stress Moderate stress Greatly stressed

20. Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke? Current every day smoker Current sometimes smoker

Do you drink alcohol and caffeine? Yes No, If so how often: _____

21. Please describe your sleeping position at night.

- Side Sleeper Back Sleeper Stomach Sleeper

How old is your mattress (approx) _____ How many pillows do you sleep with? _____

22. Do you have a history of:

- Cancer Diabetes Heart Disease Motor Vehicle Accident Surgery Hospitalization Pacemaker

If yes, please explain: _____

23. Are you:

- Right Handed Left Handed

24. Height _____ Weight _____ Blood Pressure _____/_____

PATIENT ACKNOWLEDGEMENTS OF CHATHAM CHIROPRACTIC CENTER
PLEASE READ THE FOLLOWING CAREFULLY BEFORE INITIALING

Insurance Information – Copayments and Responsibility

Payment is required for all services at the time they are rendered. **I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of treatment rendered and it is my responsibility to understand my healthcare coverage including copayments, deductibles and coinsurance and VISIT LIMITS.** Checks returned for insufficient funds will be charged an additional \$50.00 fee. An administrative fee of \$10.00 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or collection fee, at the provider’s current rate may be charged on all past due balances owed to the provider. Your signature below signifies your understanding and willingness to comply with this policy.

Patient / Guardian Initials _____

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Physician and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral, the expiration date of my referral, and obtain new referrals as needed. I understand that should I fail to have a valid referral for my visits, your insurance company will deny the claim. The office will reschedule my appointment or the cost of the visit will become my responsibility.

Patient / Guardian Initials _____

Insurance Cards

New patients or those with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. If I am unable to present one, I may pay in full at the time of service and submit a claim to my insurance carrier at my convenience. I understand by signing below that I am responsible for notifying the office of any changes to my insurance/contact information.

Patient / Guardian Initials _____

Cancellation/ No Show Policy

Should you be unable to keep your appointment, please contact the office 24 hours prior to your appointment to cancel. Missed appointments or “No Shows” will result in a \$50.00 fee after two consecutive missed appointments. This fee is not reimbursable by your insurance company. If you are running late, but plan on keeping your appointment, out of courtesy to us and other patients, call the office as soon as possible. We will do our best to adjust our schedule accordingly.

Patient / Guardian Initials _____

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits Chatham Chiropractic Center from discussing appointments, medication, test results, or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

Name of Individual _____ Relationship to Patient _____

Name of Individual _____ Relationship to Patient _____

I acknowledge the practice’s adherence to the Notice of Privacy Practices related to the Health Insurance Portability and Accountability act of 1996 and may request a personal copy at any time.

SIGNATURE: _____ TODAY’S DATE: _____

INFORMED CONSENT

TO THE PATIENT: Please read the *ENTIRE* document prior to signing it. It is important that you understand the information contained in this document. If anything in this document is unclear to you please make sure to ask questions before signing.

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. This may cause an audible “pop” or “click” much as you would experience when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

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

Spinal manipulative therapy	Palpation	EMS
Range of motion test	Orthopedic Testing	Ultrasound
Basic Neurological testing	Muscle strength Testing	Laser Therapy
Postural Analysis	Hot/Cold Therapy	
Other	Vital Signs	

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 may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costo vertebral strain 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 an 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 the 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
- *Hospitalization
- *Surgery

If you choose 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 of 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 become complicated treatment making it more difficult and less effective the longer it’s postponed.

PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with _____ 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.

Date: _____

Date: _____

Patient/Guardian Signature: _____

Doctor’s Signature _____

SPECIFIC AUTHORIZATIONS

- I give permission to Chatham Chiropractic Center to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, holiday related cards, information about treatment alternatives or other health related information.

- If Chatham Chiropractic Center contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

By signing this form you are giving Chatham Chiropractic Center permission to use and disclose your protected health information in accordance with directives listed above.

***You have the right to revoke your authorization at any time, please ask for details regarding this.**

Patient Signature: X _____ EXP. Date _____

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that Chatham Chiropractic Center has informed me of the Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of my protected health information created, received or maintained by the practice. If I would like a copy, I understand that Chatham Chiropractic Center will be able to supply one for me at the time I request it. I also understand that it is posted on the Chatham Chiropractic bulletin board available for me to read anytime.

I understand that Chatham Chiropractic Center protects my medical information by using encrypted e-mail and password protected computers which are accessible only by doctors and staff at Chatham Chiropractic Center.

SIGNATURE

PRINT NAME