WELCOME TO ADVANCED CHIROPRACTIC SOLUTIONS!

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PATIENT INFORMATION

Thank you for choosing Advanced Chiropractic Solutions for your chiropractic care needs! Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

Name: _____ SSN#: _____

First Middle Last

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ____ Female ____ Male Birthdate: _____ Email Address: _____

Home Phone: [____] _____ Cell Phone: [____] _____ Work Phone: [____] _____

Do you prefer to receive calls at: ___ Home ___ Work ___Cell ___No preference

___ Married ___ Widowed ___Single ___Minor ___Separated ___Divorced ___Partnered for ____ years

Patient Employer/ School: _____ Occupation: _____

Employer/ School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: [____] _____

Whom may we thank for referring you to us? _____

Have you ever visited our website before? _____

Person to contact in case of emergency?_____ Phone: [____] _____

INSURANCE CARD(S)

CONDITION

Reason for the visit: _____ When did you first notice the symptoms? _____
Is the condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? _____ Sitting _____ Standing _____ Walking _____Bending
_____Lying Down _____ Other: _____
Type of Pain: _____ Sharp _____Dull _____ Throbbing _____Numbness _____Aching _____Shooting
_____ Burning _____ Tingling _____Cramps _____Stiffness _____ Swelling _____ Other: _____
Rate the severity of your pain (1= mild pain or discomfort, to 10= severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you received for your condition? ____ Medication _____ Surgery _____ Physical Therapy
Other: _____
Name and address of the other doctor(s) who have treated you for your condition: _____
_____

HEALTH HISTORY (Check only those conditions which are applicable)

_____ Aids/ HIV
_____ Alcoholism
_____ Allergy Shots
_____ Anemia
_____ Anorexia
_____ Appendicitis
_____ Arthritis
_____ Asthma
_____ Bleeding Disorders
_____ Breast Lump
_____ Bronchitis
_____ Cancer
_____ Ulcers
_____ Cataracts
_____ Chemical Dependency
_____ Chicken Pox
_____ Depression
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Fractures
_____ Glaucoma
_____ Goiter
_____ Gonorrhea
_____ Gout
_____ Heart Disease
_____ Hepatitis
_____ Hernia
_____ Herniated Disc
_____ Herpes
_____ High Cholesterol
_____ Kidney Disease
_____ Liver Disease
_____ Measles
_____ Migraine Headaches
_____ Miscarriage
_____ Mononucleosis
_____ Multiple Sclerosis
_____ Mumps
_____ Osteoporosis
_____ Pacemaker
_____ Parkinson's Disease
_____ Pinched Nerve
_____ Pneumonia
_____ Polio
_____ Prostate Problems
_____ Prosthesis
_____ Psychiatric Care
_____ Rheumatoid Arthritis
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Stroke
_____ Suicide Attempt
_____ Thyroid Problems
_____ Tonsilitis
_____ Tuberculosis
_____ Tumors/ Growths
_____ Typhoid Fever
_____ Vaginal Infections
_____ Venereal Disease
_____ Whooping Cough
_____ Other:_____
_____
_____
_____

Dates of last exams: _____
List any types of surgeries which you have had and the dates which they occurred: _____
_____
Please list all medications you are currently taking: _____
Allergies: _____
Women: Are you pregnant? ____ Yes ____ No Nursing? ____Yes ____ No Taking birth control pills? ____Yes ____ No

DAILY HABITS

What type of exercise do you perform on a daily basis? _____ None _____ Moderate _____ Heavy
What do your daily work habits include? _____
What vitamins do you currently take? _____ Nutritional supplements? _____
Do you smoke? _____ Yes _____ No How much per day? _____
How much alcohol do you consume weekly? _____
How many caffeinated beverages do you consume daily? _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that, and/ or my dependent(s), have insurance coverage with and assign directly Advanced Chiropractic Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Advanced Chiropractic Solutions may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

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INFORMED CONSENT TO TREATMENT

Nature of chiropractic treatment: The doctor will use his/her hands or mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry hydrotherapy may be use.

Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days or treatment. The ancillary procedures could produce skin irritation, burn, or minor complications.

Probability of risks occurring: the risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of an aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million and can be even further reduced by screening procedures. The probability adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- Over the counter analgesics. The risk of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.
- Medical care. Typically, anti-inflammatory drugs, tranquillizers, and analgesics. Risks of these drugs include a multiple of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.
Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full contest to treatment.

Printed Name	Signature	Date

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Dear Patient,

Beginning April 14th, 2003, healthcare facilities are required by federal government to comply with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT. This program is to protect the way your health records are stored and conveyed and dictates to whom they are revealed.

The attached “Notice of Privacy Practices” describes how medical information about you may be used and disclosed and will be utilized by our office. We will attempt to answer/clarify any questions or concerns that you may have or put you in contact with someone who can.

Rest assured that your privacy is very high priority with our office. We will continue to treat you with the privacy and dignity you deserve.

By signing below, I acknowledge that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

I give the authority to release my health and/or account information to the following individual[s]: _____
[Name and relationship to you]

_____ _____
Name of Individual [printed] Signature of Individual

_____ _____
Signature of Legal Representative Relationship to Individual

Date Signed: _____/_____/_____ Witness: _____