PATIENT INFORMATION

Patient ID (Keytag Number) _____

First Name: _____ Last Name: _____

Gender: ❑ M ❑ F Date of Birth: ____/____/____ Age: _____ SS#/SIN: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ ❑ W ❑ H ❑ C 2nd Phone: _____ ❑ W ❑ H ❑ C

Email: _____

What is your preferred method of communication? ❑ Phone ❑ Text ❑ Email

Employer: _____ Occupation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____ ❑ W ❑ H ❑ C

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ❑ Yes ❑ No

Name of the person responsible for this account: _____ Relationship to Patient: _____

Is the person currently a patient at our office? ❑ Yes ❑ No

Do you have Medical Insurance? ❑Yes ❑No If yes, complete the following:

Name of the Primary Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#: _____ Name of Employer: _____ Work Phone: _____

Address of Employer: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Group #: _____ ID# _____

How did you first hear about Southtown Chiropractic? _____

_____

If you were referred by someone, please tell us who so we may thank them. _____

_____

Patient or Legal Guardian Signature Date

PATIENT HISTORY

Name: _____ Age: _____ Date of Birth: ____/____/____ Gender: ❑ M ❑ F

Height: _____ft_____in Weight: _____lbs Occupation: _____ How long: _____yrs_____mos

1. Have you had chiropractic care before? ❑ Yes ❑ No If yes, how recently? _____

2. Reason for today's visit:

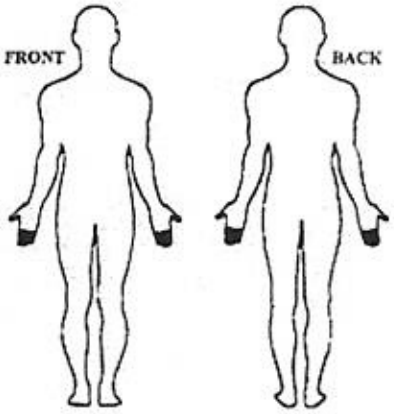
❑ Pain ❑ Discomfort ❑ Stiffness ❑ Maintenance Care ❑ Recent Injury ❑ Previous Injury ❑ Other _____

3a. When did your complaint(s) first begin? _____ 3b. Today, is the condition: ❑ Same ❑ Better ❑ Worse

Explain what helps and/or worsens the condition: _____

4. Where is/are your area(s) of complaint today? Check all that apply.	Rate pain and discomfort between 1-10 1 = Minimal 10 = Severe	Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed/ Swollen	Constant	Intermittent
❑ Headache/Migraine										
❑ Neck										
❑ Shoulders										
❑ Arm(s)										
❑ Elbow(s)										
❑ Wrist(s)										
❑ Upper Back										
❑ Middle Back										
❑ Lower Back										
❑ Hip(s)										
❑ Sciatica										
❑ Knee(s)										
❑ Ankle(s)										
❑ Other										

5. Use the figures below to place an "X" on the specific area(s) where you are experiencing pain, discomfort or limited range of motion.



For Clinic Use Only: BP ____/____

6. Have you experienced this/these complaints before: ❑ Yes ❑ No

If yes, when? _____

7. Are you pregnant: ❑ Yes ❑ No ❑ N/A If yes, how many weeks? _____

8. Are you currently experience any of the following?

❑ Nausea or vomiting ❑ Rapid eye movement ❑ Numbness on one side of the face or body ❑ Fainting or lightheadedness ❑ Dizziness

❑ Difficulty walking ❑ Difficulty speaking ❑ Headache or neck pain ❑ Difficulty swallowing ❑ Double vision

(If yes to any, please describe) _____

9. Current prescriptions or over the counter medications: _____

PAST HISTORY

MUSCULOSKELETAL CONDITIONS (please check all that apply)

❑ Headaches/Migraines ❑ Hip Pain/Discomfort ❑ Arthritis

❑ Neck Pain/Discomfort ❑ Sciatica ❑ Fused/Fixated Joints

❑ Shoulder Pain/discomfort ❑ Elbow Pain/Discomfort ❑ Herniated Disc

❑ Upper Back Pain/Discomfort ❑ Wrist Pain/Discomfort ❑ Joint Replacement

❑ Middle Back Pain/Discomfort ❑ Knee Pain/Discomfort ❑ Osteoporosis

❑ Low Back Pain/Discomfort ❑ Ankle Pain/Discomfort ❑ Osteopenia

❑ Inflammation/Swelling: where _____

OTHER CONDITIONS

❑ Cancer ❑ Heart Disease

❑ Tumors ❑ AIDS/HIV

❑ Stroke ❑ Diabetes

❑ Seizure Disorders ❑ Hepatitis

❑ High Blood Pressure ❑ Tuberculosis

❑ Pacemaker ❑ Hernia

❑ Allergies

❑ Other _____

10. Indicate if you have experienced any of the following and mark how recently.

Surgeries: ❑ Yes ❑ No – ❑ Less than one month ❑ 1-6 months ❑ 6-12 months ❑ More than 12 months _____ yrs.

Accidents/Broken bones: ❑ Yes ❑ No – ❑ Less than one month ❑ 1-6 months ❑ 6-12 months ❑ More than 12 months _____ yrs.

Hospitalizations: ❑ Yes ❑ No – ❑ Less than one month ❑ 1-6 months ❑ 6-12 months ❑ More than 12 months _____ yrs.

If yes to any, list and describe: _____

11. Family Health History (check all that apply): ❑ Cancer ❑ Tumors ❑ Stroke ❑ Seizures ❑ Diabetes ❑ High Blood pressure ❑ Heart Disease

_____

Patient or Legal Guardian Signature Date

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 understand that Dr. Gans will administer to me the treatment she deems necessary to improve my physical condition, in addition she will likely give me procedures throughout my treatment for me to perform at home that will assist my recovery and compliance that can lead to reach the outlined treatment goals. I understand Dr. Gans will give me her recommendations for a full treatment program based on my overall physical needs and my current physical condition. I also understand that Dr. Gans will give me treatment recommendations for short term goals to be met which are integral to my rehabilitative process.

I understand that while Dr. Gans and her staff agree to treat me, she cannot personally guarantee any results. I understand that Dr. Gans will advise me of advantages and complications, if any, as well as other treatment options should they become necessary.

I understand Dr. Gans has a team of physicians she works with, and if necessary, may refer me to a specialist for a second opinion or further treatment. I authorize the release of any information Dr. Gans deems appropriate concerning my physical condition to my insurance company, attorney, or other health care providers I am referred to for procedures scheduled outside this clinic. I release Dr. Gans and her staff from any consequence or liability thereof.

Do Not Sign Until You Have Read and Understand the Above:

I have read the above explanation of the chiropractic adjustment, acupuncture treatment and related treatment. I have had opportunity to ask questions and get them 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 to my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Your Insurance does not cover Maintenance Care

What is Maintenance care?

Maintenance care is defined as a treatment plan that seeks to:

- Prevent disease
- Promote health
- Prolong and enhance the quality of life
- Or therapy that is performed to maintain or prevent deterioration of a chronic condition such as arthritis.

When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. At this point most patients are not experiencing pain.

Maintenance care or sometimes called wellness care might be suggested for you after you have gone through your initial treatment plan and after any more corrective care that may be needed. Patients on maintenance care generally come in once a month. See your booklet for more details.

What is your investment associated with maintenance care?

- Chiropractic adjustment to one or two areas of the spine-$36
- Chiropractic adjustment to three or more areas of the spine-$40
- Electrical muscle stimulation-$12
- Ultrasound-$12
- 30 minute massage-$40

Medical Research Supports Chiropractic Maintenance Care

Two research studies generated by the medical profession in 2011 add evidence in support of the value of chiropractic maintenance care.

The first study published in January 2011 in Spine concluded that "SMT (spinal manipulation therapy) is effective for the treatment of chronic non specific LBP. To obtain long-term benefit, this study suggests maintenance spinal manipulations after the initial intensive manipulative therapy."

The second study in April 2011, published in the Journal of Occupational and Environmental Medicine, provides additional support for the value of chiropractic maintenance care for post injury low back pain patients. The study followed 894 injured workers for a period of one year. During that year there were four different types of therapy available to the workers: medical management, physical therapy, chiropractic, and no therapy. Episodes of repeat disability were recorded during the year following the initial injury. Physical therapy had the highest percentage of reinjured workers followed by those receiving medical management or no treatment at all. **The lowest incidence of repeat injury was found among those workers who had received chiropractic maintenance care.**

Department of State Health Services
Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective July 20, 2015), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____

Personal Representative Name (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement ofreceipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please be specific):

_____

_____

_____

Employee Signature Date