CONSULTATION

(To be completed by the doctor.)

Date: _____ Patient Name: _____

Chief Complaint:

Other Symptoms/History:

Pain Gauge

How long have you had this problem? _____

Has this happened before? _____

Did anything cause or contribute to the problem? _____

FIRST NOTICED? Worse...

1. During Night 2. Upon Waking 3. During Day - AM / PM

Any radiation of pain into an extremity? _____

What does your pain feel like?

1. Burn Ache Throb Shooting Constrict 2. Intermittent Constant 3. Dull Sharp

What movement makes the pain worse? _____

Does any certain position relieve the pain? _____

Have you seen other doctors? _____

Have you had x-rays taken? _____

Has your condition affected your daily activities? _____

Self-Help? 1. Heat 2. Ice 3. Medication 4. Other _____

Hospital/Surgery? _____

Accidents? 1. Auto 2. Job 3. Sport 4. Falls _____

Any Fractures? _____

Are you currently taking any supplements, medication or birth control? _____

Been to a chiro before? 1. YES 2. NO If yes, how often: _____

Notes: _____

Patient/Insurance Info

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: S M D W AGE: _____ SEX: M F

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

BIRTHDATE: _____ SOCIAL SECURITY #:_____

(SS# For Medicare patients only)

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____

Is your visit today due to:

☐ Auto Accident? Injury Date: _____ State in which accident occurred: _____

☐ Work Injury? Injury Date: _____

☐ Other Injury? Injury Date: _____

Primary Insurance Carrier: _____

Policy Holder: (person's name) _____

Your Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Information (if other than "self")

Employer: _____ Birthdate: _____ SS#: _____

Secondary Insurance Carrier: _____

Policy Holder: (person's name) _____

Your Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Information (if other than "self")

Employer: _____ Birthdate: _____ SS#: _____

It is mandatory to add a credit card on file. All card information will be stored securely.

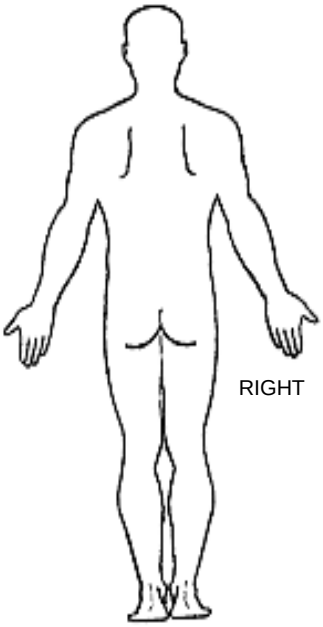
Credit Card Number: _____

Expiration Date: _____

CVV: _____

CASE HISTORY

Patient Name_____



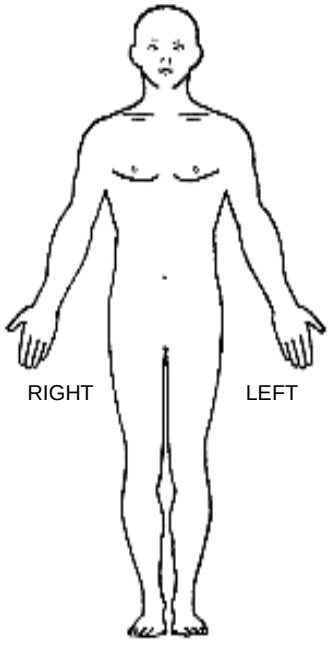
SEVERITY OF PAIN
List region of pain and circle severity number. [1 = least, 10 = greatest]

example: neck
1 2 3 4 5 6 7 8 9 10

MARK PAIN AREA

++++	Burning
0000	Stabbing
xxxx	Sharp
||||	Constant

1. _____
1 2 3 4 5 6 7 8 9 10
2. _____
1 2 3 4 5 6 7 8 9 10
3. _____
1 2 3 4 5 6 7 8 9 10
4. _____
1 2 3 4 5 6 7 8 9 10
5. _____
1 2 3 4 5 6 7 8 9 10



Please mark area of pain on the drawing using the code listed above.

PLEASE GIVE MOST CURRENT DATE OF:

Spinal Exam _____
Disc Exam _____
X-ray Exam _____
Lab Exam _____
Last Physical _____
FEMALE ONLY
Pap Smear _____
Breast Exam _____

DOCTOR'S USE ONLY

_____
_____
_____
_____
_____
_____
_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____541	Appendicitis	____285.9	Anemia	____429.9	Heart Disease	____716.9	Arthritis
____541	Pneumonia	____285.9	Measles	____429.9	Goiter	____716.9	Epilepsy
____541	Rheumatic Fever	____285.9	Mumps	____429.9	Influenza	____716.9	Mental Disorder
____541	Polio	____285.9	Chicken Pox	____429.9	Pleurisy	____716.9	Lumbago
____541	Tuberculosis	____285.9	Diabetes	____429.9	Alcoholism	____716.9	Eczema
____541	Whooping Cough	____285.9	Cancer	____429.9	Venereal Infection	____	AIDS

HABITS

☐ Smoking Packs/Day _____
☐ Drinking Alcohol _____
☐ Coffee Cups/Day _____

EXERCISE

☐ None
☐ Moderate
☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of _____	☐	☐	☐	☐	☐
Sister, No. of _____	☐	☐	☐	☐	☐

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other
	_____		_____		_____
	_____		_____		_____

Are you presently taking any medications – prescription or over-the-counter? ☐ No ☐ Yes

What drugs? _____

CASE HISTORY

(continued)

Patient Name_____

Please enter a "2" (for previously) or a "3" (for presently), in front of all the signs and symptoms below that you have/have been afflicted with. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

____784.0 Headache
____780.6 Fever
____780.9 Chills
____780.8 Night Sweats
____780.2 Fainting
____780.4 Dizziness
____780.3 Convulsions
____780.52 Loss of Sleep
____780.7 Fatigue
____799.2 Nervousness
____783 Loss of Weight
____782 Numbness or pain in arms/legs/hands
____995.3 Allergy (what)
____786.09 Wheezing
____729.2 Neuralgia

MUSCLES & JOINTS

____ Weakness
____ Twitching
____847 Stiff Neck
____722.10 Backache
____719 Swollen Joints
____781 Tremors
____729.5 Foot Trouble
____724.79 Painful Tail Bone
____724.5 Pain Between Shoulders
____563.3 Hernia
____737.3 Spinal Curvature

GASTRO-INTESTINAL

____783 Poor Appetite
____536.8 Poor Digestion
____994.2 Excessive Hunger
____787.3 Belching or Gas
____787 Nausea
____787 Vomiting
____578 Vomiting Blood
____536.8 Pain over Stomach
____564 Constipation
____558.9 Diarrhea
____789 Colon Trouble
____455.6 Hemorrhoids (Piles)
____785.1 Liver Trouble
____782.4 Jaundice
____575.9 Gall Bladder Trouble

CARDIO-VASCULAR

____783 Rapid Heart
____427.89 Slow Heart
____401.9 High Blood Pressure
____458.9 Low Blood Pressure
____786.51 Pain over Heart
____738 Previous Heart Trouble
____719.07 Swelling Ankles
____759.9 Poor Circulation
____ Varicose Veins
____436 Strokes

EYE/EAR/NOSE/THROAT

____368.9 Poor Vision
____378.9 Crossed Eyes
____379.91 Pain in Eyes
____389.9 Deafness
____388.70 Earache
____388.30 Ear Noises
____388.60 Ear Discharges
____478.1 Nasal Obstruction
____784.7 Nose Bleeds
____462 Sore Throats
____784.49 Hoarseness
____477.9 Hay Fever
____493.9 Asthma
____460 Frequent Colds
____240.9 Enlarged Thyroid
____463 Tonsillitis
____686.9 Sinus Trouble

SKIN OR ALLERGIES

____368.9 Skin Eruptions
____698.9 Itching
____278.8 Bruising Easily
____701.1 Dryness
____ Boils
____782 Sensitive Skin
____708.9 Hives or Allergy
____692.9 Eczema
____ Medicines
_____
_____

RESPIRATORY

____786.2 Chronic Cough
____786.3 Spitting Blood
____933.1 Spitting Phlegm
____786.50 Chest Pain
____786.09 Difficulty Breathing

GENITO-URINARY

____788.3 Frequent Urination
____788.1 Painful Urination
____599.7 Blood in Urine
____592 Kidney Infection
____788.3 Bed Wetting
____788.1 Inability to control urine
____601.9 Prostate Trouble

FOR WOMEN ONLY

____786.2 Painful Periods
____626.2 Excessive Flow
____626.4 Irregular Cycle
____627.2 Hot Flashes
____625.3 Cramps or Backaches
____634.9 Miscarriage
____623.5 Vaginal Discharge
____ Pregnant at this time
____ Last Pap
By Whom _____
Other _____

List accidents or falls, and dates: • Car _____ • Recreational Vehicle _____ • Sports _____

• School _____ • Other _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? • No • Yes Why? _____

Have you ever had any spinal taps or spinal injections? • No • Yes

Were you ever knocked unconscious? • No • Yes

Have you ever had a lapse of memory? • No • Yes

Have you ever had x-rays taken? • No • Yes When? _____ By Whom? _____

For what ailments were these x-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

It is understood and agreed that the amount paid to Downtown Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of the office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient Signature: _____ Date: _____

CHIROPRACTIC DOCTOR- PATIENT INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions.

ANALYSIS
A Doctor of Chiropractic (DC) conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

DIAGNOSIS
Although DC's are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the DC, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic test, diagnosis, and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not give a Chiropractic adjustment, or health care, if he/she is in a state that such care may be contra-indicative. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the DC. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The DC is licensed in a special practice and is available to work with other types of providers/specialists in your health care regime.

INFORMATION ABOUT POSSIBLE RISKS OF TREATMENT
DC's, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your DC.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physio-therapy burns. These are extremely rare occurrences.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped by medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great power in alleviating pain and controlling disease.

TO THE PATIENT
I have read, and understand the foregoing.

_____ Signature _____ Date

PATIENT CONSENT, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient/Client Name _____ Patient/Client ID# _____ (if applicable)

Consent for Treatment & Use of Records

I, the undersigned, voluntarily consent to treatment by the practioners and clinical staff of the Downtown Chiropractic Health & Sports Injury Clinic. I also voluntarily consent to the use and disclosure of my protected health information (PHI) for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) without a written authorization.

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me. If this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company. I accept personal responsibility for all un-paid balances from my claim based on their rejection of payment. I acknowledge that not all services provided by Downtown Chiropractic Health & Sports Injury Clinic are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of Downtown Chiropractic Health & Sports Injury Clinic as an Out-of-Network provider, and/or my failure to provide my insurance card. I acknowledge that physical therapy, acupuncture, and massage services are not covered by all insurance carriers, and I agree to be financially responsible for those services.

Authorization (PLEASE COMPLETE):

I authorize payment directly to the Downtown Chiropractic Health & Sports Injury Clinic for services for which Downtown Chiropractic Health & Sports Injury Clinic accepts payment. I accept responsibility for all charges if l do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

Downtown Chiropractic Health & Sports Injury Clinic is authorized to use the payment information I have provided them to auto run any balance owed on my account.

_____ _____

Patient Signature Date

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. Downtown Chiropractic Health &Sports Injury Clinic will seek to notify parents in the event of an emergency.

_____ _____

Parent or Legal Guardian Signature for a minor Witness Signature Date

CONSENT FOR TELEPHONE AND EMAIL APPOINTMENT REMINDERS AND TREATMENT ALTERNATIVES

Your chiropractor and members of the practice staff may need to use your name, address, phone number, email address, and your clinical records to contact you with appointment reminders, and information about treatment alternatives. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are consenting for us to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Information that we use or disclose based on this consent may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you choose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give us this consent or revoke it in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders or information about treatment alternatives at any time.

This consent is effective as of _____. Unless you otherwise revoke it, this consent will expire one year after the date on which you last received treatment or services from us.

I CONSENT to my phone number and/or email address being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

_____ _____
Patient Name Printed Date

_____ _____
Patient (or Personal Representative) Signature Authorized Provider Representative

_____ _____
Personal Representative's Name Printed Personal Representative's Authority

Preferred Telephone Number for This Purpose: _____ ☐ Home ☐ Cell ☐ Work

Preferred Email Address for This Purpose: _____ ☐ Personal ☐ Work

I am acknowledging that I have received a copy of this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my name, address, phone number, email address, and my clinical records to contact me with appointment reminders, and information about treatment alternatives.

_____ _____
Patient Name Printed Date

_____ _____
Patient (or Personal Representative) Signature Personal Representative's Authority

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Authorized Provider Representative
Personal Representative's Name Printed	Personal Representative's Authority

I am acknowledging that I have received a copy of the PRIVACY POLICY and this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Personal Representative's Authority