**PATIENT INFORMATION**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

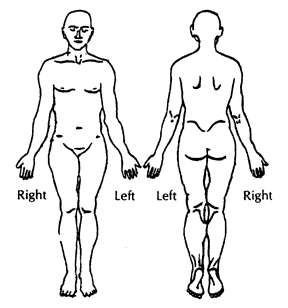
Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone #

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_

Have you had chiropractic care? Yes / No If yes, how recently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Eligible? Yes/ No

|  |
| --- |
| **PATIENT HISTORY**  **Reason for today’s visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When did your complaint begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What caused your pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Today the condition is? Better☐ Worse☐ Same☐ **What helps and/or worsens your pain**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had this condition before? Yes☐ No☐ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you seen another doctor for this? Yes☐ No☐ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you participate in sports or activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you Pregnant? If so, how many weeks?\_\_\_\_**\_\_\_\_\_\_\_\_** What position(s) do you sleep in? Back ☐ Side ☐ Stomach ☐  Please circle any that you are currently experiencing: *Nausea or Vomiting, Fainting, Dizziness, Lightheadedness, Double Vision, Difficulty with Walking, Talking, or Swallowing, Numbness, Rapid Eye Movement.* Please describe any that are circled\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current prescriptions or OTC medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other health concerns at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Use the figures to the right:**

*Rate your pain and discomfort on the figures between* **1-10(10=severe)**

**Please circle all that apply:**

*Type of Pain:* ***Radiating, Sharp, Dull, Tingling, Numbness, Burning***

*Frequency of Pain*: **Constant / Intermittent**

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**HEALTH HISTORY:** (*check all that apply*)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Headaches/Migraines |  | Sciatica |  | Scoliosis |  | Osteopenia |  | High Blood Pressure |  | Vertigo |  |
| Neck Pain |  | Shoulder Pain |  | Herniated Disc |  | Arthritis |  | Pacemaker |  | Allergies |  |
| Upper Back Pain |  | Elbow Pain |  | Bulging Disc |  | Cancer |  | Heart Disease |  | Diabetes |  |
| Mid Back Pain |  | Wrist Pain |  | Fused Joints |  | Tumors |  | AIDS/HIV |  | Tobacco Use |  |
| Low Back Pain |  | Knee Pain |  | Joint Replacement |  | Stroke |  | Hernia |  | Alcohol Use |  |
| Hip Pain |  | Ankle Pain |  | Osteoporosis |  | Seizures |  | Tuberculosis |  | Drug Use |  |

|  |
| --- |
| Other Conditions: |

**FAMILY HISTORY:** (*check all that apply*)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Cancer |  | Tumors |  | Stroke |  | Seizures |  | Diabetes |  | Heart Disease |  | High Blood Pressure |  |

|  |
| --- |
| ***Have you experienced any surgeries, accidents, broken bones, and/or hospitalizations? Yes/No***  If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_  If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_  If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_ |

**Notice of Privacy Practices**

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). Signing this consent allows Spine Club Chiropractic to use and disclose my protected health information for: Treatment, Consultation with other health care providers and clinic staff about your case, and daily healthcare operations within the practice.

I acknowledge that a detailed Notice of Privacy Practices may be found at spineclubs.com and that a copy is available for me by request. I understand that Spine Club Chiropractic reserve the right to change the terms of this notice and that I may contact you at any time to get a current copy.

I understand that I have the right to request restrictions on how my PHI is used and disclosed but that you are not required to agree to these requests. I understand that I may request a copy of my health information.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date is not affected.

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my health.**

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**Patient Signature or Legal Guardian Date**

**INFORMED CONSENT TO CHIROPRACTIC 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

**Financial Responsibility**

All patients acknowledge that they are financial responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing information or related claims for, or on, their behalf to any private insurance, Medicare, Medicaid, Secondary Insurance provider with whom they have insurance coverage. Furthermore I understand that Spine Club Chiropractic will not submit any billing information or related claims for lawsuits, motor vehicle accidents, workman’s compensation, or any other ongoing or past legal dispute.

Patient Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent To Evaluate and Treat A Minor**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_being the parent or legal guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand all information provided in the patient intake forms and hereby grant permission for my child(ren) to receive chiropractic care and treatments including adjustments.

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