TRUE NORTH CHIROPRACTIC ● DR. JAKE WILLIAMS, B.Sc., D.C.

First Visit

Today, you will receive a comprehensive spinal and postural examination, consultation, history and referral for any necessary X-rays

Second Visit

After the examination, if your doctor determines that you are a good candidate for reconstructive or structural chiropractic care, he will then arrange for your next visit, which is the REPORT OF FINDINGS (ROF). The Purpose of this visit is to review the findings from your consolation and examination

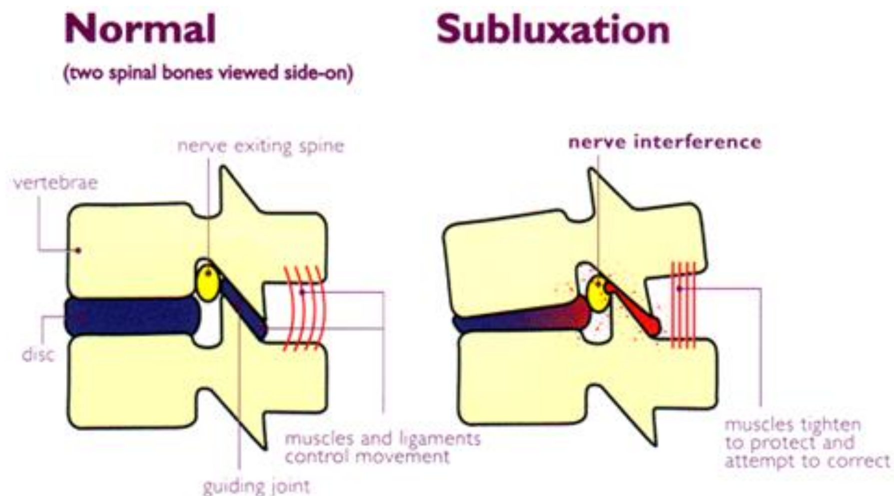
At the ROF, the doctor will give a detailed overview of how **Chiropractic** works and the scientific evidence supporting the specialized work that we do here.

We know that there is **tremendous power in you fully understanding** your problem and how we will work with you to correct it. That is why the ROF is detailed and very informative. Your spouse is invited to the ROF because we know that having support and understanding at home is important to your complete recovery.

After the ROF, Dr. Jake will review the results of your EXAMINATION AND X-RAYS. HE WILL OUTLINE A COURSE OF CARE, discussing how long it will take to correct your spine, how often you will come in for adjustments, and the financial investment for your care and correction. At that point you will be able to decide how you would like to proceed.

YOU ARE IN GOOD HANDS. Your Health is our #1 Priority.

We correct a devastating health condition known as SUBLUXATION. Subluxations are misalignments of the spine that cause nerve interference in your central nervous system. The central nervous system is responsible for all functions, healing and regeneration in your body. Every organ, system, cell and tissue are under control of the nervous system.



Our focus is to correct subluxation in order to remove nerve interference in your central nervous system. This will allow your body to heal naturally at its full potential.

Our purpose is to help you and your family live happier, healthier and longer lives through natural chiropractic care.

Thank you for giving us the privilege to determine if we can help you OPTIMIZE YOUR HEALTH.

Sincerely,

Dr. Jake Williams, B.Sc., D.C.

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Health Questionnaire

Patient Information

Dr. / Mr. / Mrs. / Ms. / Miss *(circle one)* Marital Status *(circle one)* M S W D

Patient Name: ______________________________ Nick Name: ____________________

Date of Birth: ____________________ SS #: ____________________ Sex: M / F *(circle one)*

Address: ____________________ City: ____________________ State: ____ Zip: _______

Hm Phone: ____________________ Cell Phone: ____________________ Wk Phone: ____________________

Email Address: ____

Occupation: ______________________________ Employer: ____________________

Who may we thank for your referral? ____

Primary Care Physician: ____________________ Phone: ____________________

In Case of an Emergency, Contact:

Name: ______________________________ Relationship: ____________________

Hm Phone: ____________________ Cell Phone: ____________________ Wk Phone: ____________________

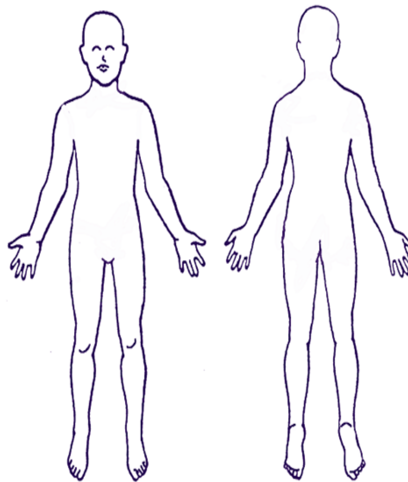
Symptoms / Major Complaints:

1.) What is your **number one** problem or the **one area** of greatest pain? ____________________

____

2.) **Body Diagram:**

X X X Sharp Pain
O O O Dull Ache
/ / / Burning Pain
^ ^ ^ Numbness
* * * Pins & Needles or Tingling



3.) Please rate the level of this pain on the following scale: **0 1 2 3 4 5 6 7 8 9 10** ***(0 is no pain, 10 is severe pain)***

4.) When did this problem/pain start? ____________________ [ ] Gradual [ ] Sudden [ ] Progressive

5.) What do you think caused this problem: ____

6.) How often do you experience the pain?
[ ] 1-2 hours per day [ ] About half of the day [ ] Most of the day [ ] The pain never goes away

7.) How does the pain affect your daily activities?
[ ] It does not affect my daily activities [ ] I have had to change how I do things
[ ] I have had to stop doing some of my daily activities [ ] I am unable to perform daily activities

8.) What **increases** your pain? ____

9.) What **decreases** your pain? ____

10.) Have you ever experienced this problem before? Y / N When? ______________________

11.) List any other complaints currently bothering you and rate your pain level for each:

a. ______________________________ **1 2 3 4 5 6 7 8 9 10**
b. ______________________________ **1 2 3 4 5 6 7 8 9 10**
c. ______________________________ **1 2 3 4 5 6 7 8 9 10**
d. ______________________________ **1 2 3 4 5 6 7 8 9 10**

12.) Have you ever been involved in an automobile accident? Y / N When? ________________
Were you injured? Y / N Explain: ______________________________________

13.) Have you ever been injured at work? Y / N When? ____________________________
Explain: ____

14.) List all medications you are currently taking *(prescribed and over the counter)* ______________

____

15.) List all surgery you have had *(with dates)* ______________________________________

____

16.) Mark a **"P"** for past conditions and/or mark a **"C"** for current conditions, on the line provided:

_____ heart attack _____ stroke _____ arthritis _____ gall bladder trouble
_____ diabetes _____ glaucoma _____ fainting spells _____ kidney stones
_____ difficulty urinating _____ bloody stools _____ difficulty with bowel movement
_____ prostate trouble _____ anemia _____ cancer _____ asthma
_____ AIDS _____ menstrual cramping _____ diverticulosis _____ ulcers
_____ dizziness _____ memory loss _____ chest pain _____ shortness of breath
_____ constipation _____ diarrhea _____ general fatigue _____ sudden weight loss
_____ nausea _____ hearing loss _____ joint soreness _____ muscle cramping
_____ ears ringing _____ headaches _____ migraine _____ epilepsy
_____ gout _____ tuberculosis _____ syphilis _____ ankle sprain: R / L
_____ knee/hip replacement _____ broken bones: ______________________________

General Activities:

_____ sleep on waterbed _____ read in bed _____ fall asleep in recliner/on couch
_____ sleep on stomach _____ needlepoint/knitting _____ use two or more pillows to sleep
_____ sewing _____ lift weights _____ play video games (________ hrs per day)
_____ exercise _______ x/wk _____ jog _______ x/wk _____ computer use (________ hrs per day)
_____ swim _____ use healthrider _____ watch television (________ hrs per day)

17.) If you do not get this problem corrected, do you think it will get worse in the next 5 years? ☐ Yes ☐ No

18.) Please add anything else you would like the doctor to know: ______________________________

____

____

______________________________________ ______________________

Patient Signature (or Legal Guardian) **Date**

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HIPAA (Health Insurance Portability Accountability Act)

Notice of Privacy Practices: Appointment Calls, Open Room Adjusting & Healthcare Information

Our HIPAA Notice of Privacy Practices describes the privacy practices of True North Chiropractic. We respect our legal obligation to keep health information private and, by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our notice that are currently in effect, and if you request, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524).

APPOINTMENT - CALLS, TEXTS & EMAIL

True North Chiropractic may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. In an effort to communicate in a more efficient and timely manner, True North Chiropractic may use email and text communications to communicate with you. These communications will include, but not limited to: appointment confirmations, scheduling, general questions and communications with mutual healthcare providers. If contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

- Authorized Email Address: ____
- Authorized Text Number: ____

OPEN ROOM ADJUSTING

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally, comments about you or other patient's symptoms, improvement or lack thereof may be discussed during and at your office visit.

HEALTHCARE INFORMATION

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decided to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.
You have the right to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the other methods we use to obtain reimbursement for your care.

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

( ) Spouse: ____ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

( ) Parent/s or Guardian/s: ____________________________ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

( ) Relative/Friend/Other:____________________________ ( )Yes, Health Info ( )Yes, Billing Info ( )Yes, Scheduling

This notice is effective as of ____________________, 20__________. This authorization will expire seven years after the date in which you last received services from us.

Acknowledgment of Receipt of this Notice

As a patient of True North Chiropractic, I acknowledge that I have received and seen this notice and understand that I may receive a copy of this form when needed. I understand that True North Chiropractic respects their legal obligation to keep health information private unless required by law. By signing below, I indicate that I agree to these conditions and I understand I authorize disclosure of my health information in the manner described above.

____

Patient Name *(Printed)*

____ ____________________________________

Patient Signature (or Legal Guardian) Date

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Informed Consent

While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care, to allow you to be fully informed before consenting to treatment.

As a part of your examination and/or treatment, the following procedures may be performed by the doctor: spinal manipulative therapy, range of motion testing, muscle strength testing, palpitation, orthopedic testing, postural analysis, vital signs, neurological testing, radiographic studies, mechanical traction, hot/cold therapy, soft tissue therapy and other procedures that the doctor deems necessary.

The primary treatment used, by Doctors of Chiropractic, is spinal manipulative therapy. Hands or a mechanical instrument may be used upon the body in such a way to move the joints. This may cause an audible "pop" or "click" from gas releasing from the joints.

Specific Risk Possibilities Associated with Chiropractic Care

Soreness – Chiropractic adjustments and any physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise the doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally, chiropractic treatment may aggravate a disc injury, or cause other minor joint, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions, such as, pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Other Problems – There are occasionally other types of side effects associated with chiropractic care, including, but not limited to, fractures, dislocations and muscle strains. While these complications described are extremely rare, the doctor will check for underlying weaknesses during your history, examination, and radiographs. However, if you have a condition that would otherwise not come to the doctors attention, it is your responsibility to inform the doctor.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in our office. In an attempt to provide you with the best care possible, if the results are not acceptable, we will refer you to another provider whom we feel can further assist you.

Having carefully read the above consent, I hereby give my informed consent to have chiropractic treatment administered and intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____

Patient Name *(Printed)*

____ ______________________

Patient or Legal Guardian Signature Date