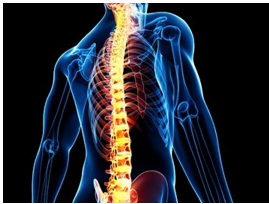


Polson Family Chiropractic
801 4th Avenue E, Polson, MT 59860
406-883-4216
polsonfamilychiropractic@gmail.com

Welcome to our office!

We are glad that you are here today! If you have any questions concerning our policies, forms, or procedures, please ask. It is our pleasure to help you!

Our Privacy Practice

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your information to:

- Treat you
- Run our office
- Inform you about other services
- Discuss your care w/ family
- Include you in care classes
- Collect payment
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Court hearings and filings
- Reporting to worker's comp.
- Reporting victims of abuse

You have the right to:

- Request a copy of your records
- Amend your protected health information
- Request confidential communications
- Ask us to limit the information we share
- Request a list of who we share your information with
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: June 15th, 2021

I acknowledge that I have read and received, or been given the opportunity to receive, a copy of the Notice of Privacy Practices.

Please initial:

______ I have read and understand the Notice of Privacy Practices.

______ I would like a hard copy of the Notice of Privacy Practices, or

______ I do not want a hard copy of the Notice of Privacy Practices

Copy of Notice of Privacy Practices received ____________ ____________

Patient Initials Office Initials

Informed Consent

When a patient seeks chiropractic healthcare, and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal, to remove interference from the nervous system. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's nervous system. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulse, resulting in lessening of the body's innate ability to express its maximum health potential.

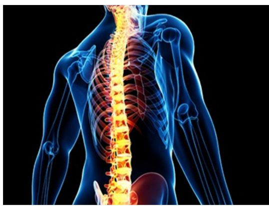
We do not offer to diagnose or treat any disease. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other providers. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

I, ___________________________________, have read and fully understand the above information.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____   _________________________
Signature   **Date**



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Application for Treatment

Name:____ Age:________ Birthdate:___________
Address:____City:_____________ Zip:_______
Phone:_____________________________ Email____
Referred to our office by: Internet; _____Phone Book; _____ Friend:_________________________
Employer/Occupation:____
Emergency Contact (Name)_____________________________ (Phone)________________________
Relationship to Patient____

Please list/describe the health problems for which you came to this office:
____
____
____
____
How/When did symptoms first occur?____
List other Doctors recently seen for these problems_______________________________________
List types of past treatment (sugery, meds, etc)____
Does this interfere with your normal living and/or work? Yes_____ No____ In what way?
____
Have you lost days of work? No_____ Yes_____ (Dates)_______________________________________
Have you had similar symptoms or injuries before? No____ Yes_____ (explain)__________________
____

Who is responsible for your bill? Self___Spouse___ Employer___ Insurance___ Other:____________
Type of Insurance (if applicable): Workers Compensation____ Health Insurance____ Auto Ins. ____

Personal History

Have you been treated for any health condition in the past year? No___ Yes___
(If yes,explain) ____
____
Have you received Chiropractic treatment recently? No____ Yes___ (If yes, when)________________

List all drugs or medications that you have used recently (aspirin, birth control, etc): _______________
____

Childhood diseases: Measles____ Mumps____ Chickenpox ____ Other:________________________
Additional illnesses, hospitalizations, or injuries:____
Surgeries: ____
Fractures: ____
Allergies: ____

Personal History (Continued)

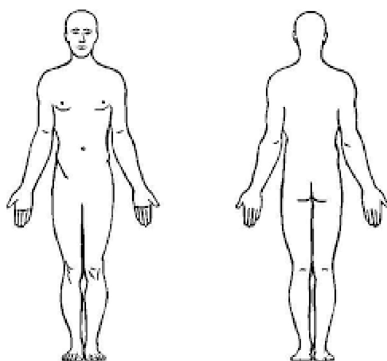
List the approximate dates of any surgeries, unusual diseases, serious illnesses or accidents you have had (include any broken bones) ____

____
Smoke No___ Yes___ (packs per day)_____ Drinks per week _____
Supplements____
Last Physician (MD/DO) visit:___________________________ Reason: _______________________

Family History

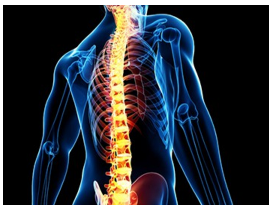
Name of wife or husband:_______________________________ Ages of children________________
Parents Ages: Father _______ Mother______
Family history of: Cancer_____ Diabetes_____ Asthma____ Arthritis_____ TB____ Heart Disease___
Stroke____ Kidney Disease____ Lung Disease____ Liver Disease____

Please mark areas of pain on the figure below:



List the conditions you are most interested in getting corrected. List in order of importance:
1.____
2.____
3.____
4.____

What functions are you unable to perform or unable to perform without pain? List in order of severity (Ex- sitting, walking, etc)
1.____
2.____
3.____
4.____



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Patient Health Questionnaire

Name: ________________________________ **Date:** ___________________________

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, please check that symptom in the Present Column. **Please note, correctly answering the conditions can influence treatment choices and outcome of care.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast – Soreness / Lumps
☐	☐	Cancer, Explain ___________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (chronic lung disorder)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R____ L____)
☐	☐	Headache
☐	☐	Heart Attack (Date)_____________
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder problems
☐	☐	Loss of Appetite
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular In-coordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle or Foot
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Pain in Upper Leg or Hip
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain
☐	☐	Stroke (Date) ____________
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain ___________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain
☐	☐	Other _________________

Have You or Your Family Had:

Yes	No	
☐	☐	Cancer
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Chronic Back Problems
☐	☐	Heart Problems
☐	☐	Chronic Headaches
☐	☐	Lung Problems
☐	☐	High Blood Pressure
☐	☐	Lupus

Do you have a permanent disability rating? Yes ____ No ____
Location ______________________________________
Date rating received? Rating Percentage _______________

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # of births ___________
☐	☐	Birth Control pills, Type __________
☐	☐	Drug or Alcohol Dependence
☐	☐	Tobacco _____ packs/day
☐	☐	Alcohol _____ drinks/day/week/month
☐	☐	Coffee/Tea/Caffeinated Drinks ___________ cups/cans per day

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition.

Fees are payable at the time when x-rays, examinations, and treatments are received unless other arrangements are made in advance. Original records remain the property of this clinic.

I hereby give permission for treatment.

Signature of Patient: ______________________________Date: ________________________

Patient Name (printed) ____________________________Guardian (if applicable)__________________

____ ____________________________________

Signature **Date**