Indian Creek Chiropractic Patient Information

Patient Name:_____ Date:_____ Date of Birth_____ Age_____
Address_____City_____ State _____ Zip Code _____
H. Phone _____W. Phone_____ Cell Phone _____
Email Address: _____ Social Security #_____
Occupation_____ Employer_____
Sex M F Marital Status M S D W Spouse Name:_____ Spouse DOB:_____

Health History:

Recent x-rays or MRI's: Region(s)_____Date(s)_____ Provider(s)_____

Previous Injuries or Traumas: _____

Past conditions:

□ Arthritis	□ CVA (stroke)	□ Headaches	□ Multiple Sclerosis	□ Shingles
□ Asthma	□ Depression	□ Heart Disease	□ Parkinson's	□ Spina Bifida
□ Cancer	□ Diabetes	□ Hepatitis	□ Pneumonia	□ Vertigo
□ Chicken Pox	□ Ear Infections	□ HIV	□ Scoliosis	□ Other_____
□ Crohn's/Colitis	□ Fibromyalgia	□ High Blood Pressure	□ Seizures	□ Other_____

Surgeries:

□ Appendectomy	□ Coronary Bypass	□ Hernia Repair	□ Laminectomy_____	□ Spinal Fusion
□ C-Section	□ Cosmetic	□ Hip Replacement (Lt / Rt)	□ Pacemaker	Level?_____
□ Carpal Tunnel	□ Gall Bladder	□ Knee Repair (Lt / Rt)	□ Rotator Cuff(Rt /Lt)	□ Other_____

Medications:

Any over the counter meds? □ No □ Yes _____
Any prescription pain meds? □ No □ Yes _____
Any prescription muscle relaxers? □ No □ Yes _____
Any other prescription meds? □ No □ Yes _____

Social and Occupational History:

Recreational activities:_____ Hobbies:_____

Children / ages:_____

Occupation/Job Title: _____
Description of Work: _____

Do you use: Alcohol Y N ____drinks/week Tobacco Y N ____pack/day

Current Condition(s):

Unwanted Condition/Pain (Why are you here today?): _____
Have you ever received Chiropractic Care? Yes No If yes, when? _____

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom right now: 0 1 2 3 4 5 6 7 8 9 10
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the worst the symptom gets: 0 1 2 3 4 5 6 7 8 9 10
- When did the symptom begin? _____
  - What makes the symptom better?_____ Worse?_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the symptom radiate to another part of your body (circle one): yes no Where?_____

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom right now: 0 1 2 3 4 5 6 7 8 9 10
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the worst the symptom gets: 0 1 2 3 4 5 6 7 8 9 10
- When did the symptom begin? _____
  - What makes the symptom better?_____ Worse?_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the symptom radiate to another part of your body (circle one): yes no Where?_____

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom right now: 0 1 2 3 4 5 6 7 8 9 10
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the worst the symptom gets: 0 1 2 3 4 5 6 7 8 9 10
- When did the symptom begin? _____
  - What makes the symptom better?_____ Worse?_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the symptom radiate to another part of your body (circle one): yes no Where?_____

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom right now: 0 1 2 3 4 5 6 7 8 9 10
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the worst the symptom gets: 0 1 2 3 4 5 6 7 8 9 10
- When did the symptom begin? _____
  - What makes the symptom better?_____ Worse?_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Does the symptom radiate to another part of your body (circle one): yes no Where?_____

Auto Accident Injury Form

Patient's Name:_____ Today's Date:_____

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of Impact: **Front / Back / Left / Right / Other**: _____

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other**: _____

2) Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

4) What type of vehicle were you in? _____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type of vehicle struck yours?_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

7) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other**: _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other**: _____

What other doctor(s) have you seen as a result of this injury? _____

Review of Systems

Name: _____ **Date:** _____

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last **MONTH**.

Constitutional/General
- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain
- ☐ Other:_____

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Wear Glasses
- ☐ Other:_____

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Nasal Congestion/Sinus Issues
- ☐ Hearing Loss
- ☐ Other:_____

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath
- ☐ Other:_____

Endocrine
- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes
- ☐ Other:_____

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Other: _____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion or Heartburn
- ☐ Blood in Stools
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties
- ☐ Other: _____

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ Other: _____

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising
- ☐ Bleeding Tendencies
- ☐ Other: _____

Genitourinary
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating
- ☐ Other:_____

Skin
- ☐ Skin Rash
- ☐ Itching
- ☐ Skin Discoloration
- ☐ Lumps or Masses
- ☐ Other:_____

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking
- ☐ Other:_____

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Convulsions/Seizure
- ☐ Other:_____

Functional Loss Assessment

Name:_____ Date:_____

(Please complete the following in complete sentences if possible.)

PERSONAL LIMITATIONS: Since the pain/discomfort started I can no longer do the following like I previously could:

_____

_____

_____

_____

_____

bathing	grooming	cooking	cleaning	vacuuming	Yard work	groceries	shopping
sexual	difficulties	watching TV	reading	Shaving	driving	shoveling	sleeping

SOCIAL LIMITATIONS: Since the pain/discomfort started I can no longer do the following like I previously could:

_____

_____

_____

_____

_____

dancing	movies	theater	walking	Running	bicycling	concerts	sports
gardening	mowing	painting	exercising	child care	swimming	decorating	shopping

WORK LIMITATIONS: Since the pain/discomfort started I can no longer do the following like I previously could:

_____

_____

_____

_____

_____

lifting	carrying	bending	pulling	Pushing	pinching	gripping	sitting
standing	bending	twisting	phone time	computer	focusing	awareness	climbing

Patient Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

(name and relationship) has permission to receive information regarding my records

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays including non-surgical spinal decompression, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the clinic of chiropractic indicated below and/or licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the clinic of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with a doctor of chiropractic or other clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I fully understand that some of the care included may not be Board/Insurance/Medically recognized and may be considered new/experimental/not medically necessary/not reimbursable/not proven, etc and agree to care on those terms.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that should I discontinue care for any reason, all fees accrued for care received are based on current clinic fee schedules and are based per visit and per service received. If I pre-paid for any care, a refund may be due after the services received have been deducted from the amount paid. All refunds are paid within 30 days of the request given in writing. Any balance on my account is due and payable immediately.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Clinic: Indian Creek Chiropractic

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

_____ _____
Office Signature Date

_____
Printed Name

Letter of Protection Fee Guarantee Agreement

Indian Creek Chiropractic

2523 S 10th Ave STE 102, Caldwell, ID 83605 (208) 649-4321

PATIENT:_____ DATE OF BIRTH:_____ ACCIDENT DATE:_____

Personal Medpay Insurance
Insurance Carrier:_____
Insurance Mailing Address:_____
_____
Claim Number:_____

Other Party's Insurance
Insurance Carrier:_____
Insurance Mailing Address:_____
_____
Claim Number:_____

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement for chiropractic services. This agreement is made in favor of the above named Healthcare Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges. The above named Patient hereby agrees that if s/he recovers any money from any person or entity in connection with any legal action related to the above noted accident date, the Patient shall withhold from those funds, sufficient money to pay the full outstanding balance of any bill(s) owed to the above named provider for treatment or any work completed in relation to the above noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend to pay any outstanding balance for any copies, costs or reports the above named Medical Provider endures in relation to any legal issue for the above accident date. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the legal action's proceeds.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. It is also the Patient's responsibility to advise the provider within 5 days of legal matter collecting any funds and to request a bill for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the provider, as soon as possible, about any funds related to the accident case becoming available to the above named Patient. Further, if the legal action fails to fully pay the provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The provider may, at his/her discretion at any time, bill any third party payer or government payer.

Disputes. If there is a dispute over the provider's outstanding charges the Patient agrees to submit the full amount due to the provider and agrees to bring an action in the state of Idaho for recovery of the disputed difference. If the Patient fails to pay the provider's full outstanding balance, and thereafter provider brings suit to collect said sums, provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

The parties agree that no party shall be considered the drafting party to this contract.

_____

PATIENT SIGNATURE **DATE**