Aspenridge
CHIROPRACTIC CENTER, P.A.
Chiropractic & Natural Health

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." ~Thomas Edison

Patient Information

Welcome! Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)
Name _____ **Date** _____ **SS#** _____

Address _____ **City** _____ **State** _____ **Zip** _____
Sex: Female ____ **Male**____ **Birth Date** _____ **Age** ____ **Height** _____ **Weight** _____

Home phone # _____ **Work phone #** _____ **Cell phone #** _____
Do you prefer to receive calls at: Home _____ **Work** _____ **Cell** _____ **Any** _____
Email Address: _____
Your Employer _____ **Occupation** _____

Are you: Minor ____ **Single** ____ **Married** ____ **Divorced** ____ **Separated** ____ **Widowed** ____
Spouse Name _____ **Spouse Birth Date**_____
Person to contact in case of an emergency _____ **Phone#** _____
Relationship to patient _____

Name of person responsible for this account _____
Relationship to patient _____ **Insurance Policy Holder Birth Date** _____
Home phone # _____**Work phone #** _____ **Cell phone#** _____
Address _____ **City** _____ **State** ____ **Zip** _____

Who may we thank for referring you to our clinic? _____

Accident or Work Related Injury

Is your condition due to an accident? yes ____ **no** ____ **/ Illness** ____ **Other** _____
Were you involved in an automobile accident? yes ____ **no** ____
Did your accident occur while at work? yes ____ **no** ____ **Injury reported to employer? yes** ____ **no** ____
Date of Injury _____

Auto or Work Comp Insurance Co. Name _____
Address _____ **Phone #** _____
Claim # _____

Have you had any other injuries or accidents? Past Year ____ **Past 5 years** ____ **Over 5 years** ____ **None** ____
_____

Do you have an attorney representing you? yes ____ **no** ____
If so, Name and Address _____
_____

_____ _____
Patients/ Parent Signature **Date**

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Health History

Have you had any problems with the following areas?

___ Eyes	___ Urinary	___ Internal Organs	___ Nerves
___ Ears, Nose, Throat	___ Muscles	___ Allergies	___ Blood
___ Psychological	___ Heart	___ Intestines/Stomach	___ Skin
___ Arthritis	___ Other: _____		

If you have checked any of these, please explain: _____

_____

Yes	*No*	
___	___	Do you commute to work? How far? _____
___	___	Do you exercise? Times per week? _____
___	___	Are you a smoker? Packs per day? _____
___	___	Do you consume caffeine? How much per day? _____
___	___	Do you consume alcohol? Glass per day/week? _____
___	___	Do you take vitamins/supplements? What kind? _____

Medications / Allergies:

Please list current medications you take and/or allergies you have:
Medications:

_____

_____

_____

Allergies:

_____

_____

Hospitalizations / Surgeries / Injuries:

Please list any hospitalizations, surgeries or injuries you have had:

_____

_____

_____

Females: Are you pregnant? _____ **Nursing?** _____ **On Birth Control?** _____

Family History:

Please list any medical conditions your family members have had. If deceased, from what:

Mother: _____ **Father:** _____

Sisters: _____ **Brothers:** _____

Children: _____

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Symptoms:

How did you injure yourself and/or what were you doing when you first noticed your pain? _____

_____

The date you first noticed symptoms? _____ **Is this condition getting progressively worse?** _____
What Makes your symptoms better? _____
What Make your symptoms worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? Sitting___ Standing___ Walking___ Bending___ Lying___
Is the pain constant, or does it come and go? _____
What treatment have you already received for your condition? Medication ___ Surgery ___ Physical Therapy___

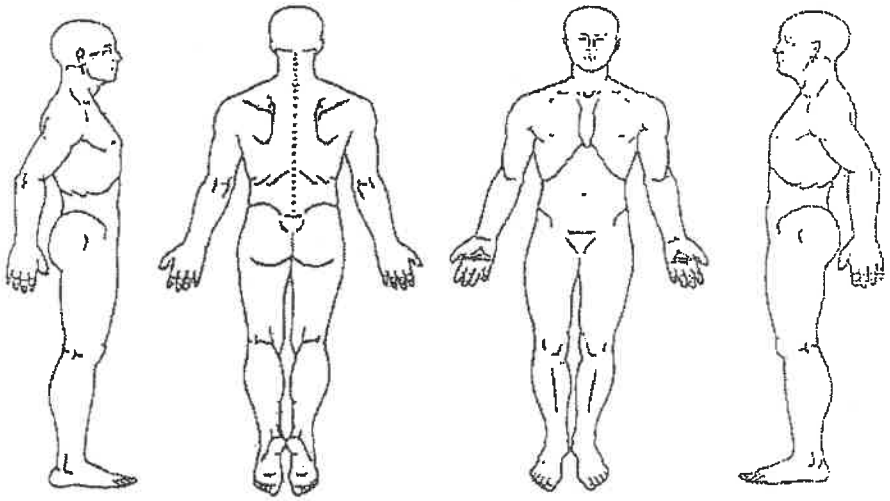
Name and address of other doctor(s) who have treated you for your condition: _____

_____

Previous chiropractic care: Doctor: _____ **Date:** _____
What have you done to relieve the symptoms: __ prescription medications __ over the counter drugs
__massage __Ice __ Heat __ Chiropractic __Acupuncture
__Physical Therapy __Homeopathic remedies __ Surgery

On a scale of 0-10, rate the intensity of the pain:
0 1 2 3 4 5 6 7 8 9 10

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:



D = Dull

B = Burning

N = Numb

S = Stabbing/Cutting

T = Tingling (Pins & Needles)

C = Cramping

Office use only:

Hight: _____

Weight: _____

Blood pressure: _____

Paulse: _____

Temp: _____

Authorization

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health.
Signature of Patient (or parent if minor) _____ **Date** _____

Acknowledgements

Chiropractic care:	☐	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Privacy Verification:	☐	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Permission to contact:	☐	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification:	☐	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification: *(females only)*	☐	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:
General Verification:	☐	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.**
2. **The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.**
3. **A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.**
4. **The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.**
5. **For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.**
6. **Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.**
7. **If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.**

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient/ Parent Signature **Date**

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Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment; therefore it is necessary to inform the patient of such risks prior to initiating care. 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 in consenting to treatment. Aspenridge Chiropractic Center uses trained staff personnel to assist you with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, and etc. Occasionally, when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE- Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions, death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10 million treatments. The most recent studies (journal of the CCA, Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

SORENESS- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic of you experience soreness or discomfort.

SOFT TISSUE INJURY- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, 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.

PHYSICAL THERAPY BURNS- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

OTHER PROBLEMS- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

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 this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist you in your situation.

I, the undersigned, hereby authorize the doctors of Aspenridge Chiropractic Center and assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to me to the results that may be obtained. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of any medical information necessary to process my insurance claim(s) and that payment be made directly to Aspenridge Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGES DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have a full understanding and consent to have care provided, please print and sign your name and date below.
HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

Patients Name Printed	**Date**
Patients Signature	**Parent/Guardian Signature for Minor**