



Confidential Patient Information

Please Print

Date: _____

Last Name	First Name	Middle Initial	Nick Name
Address	City	State	Zip Code
Home phone: _____		Mobile Phone: _____	
Email address: _____			
Social Security No.: _____		Date of Birth: _____	
Sex: <input type="radio"/> M <input type="radio"/> F			
Occupation (specific job title): _____		Employer: _____	
Work Address: _____			
PCP name/#: _____		Emerg.Contact Info: _____	

Symptoms

1. What is the one main complaint that you would like to be addressed? (List other complaints below in question #9) _____

2. Please rate your main level of pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. (If your pain varies from day to day, please circle two numbers to indicate a range of your pain.) 0 1 2 3 4 5 6 7 8 9 10
3. When did this problem start? _____ Was it: Gradual Sudden Progressive
4. What do you think caused this problem? _____
5. A. Please describe the character of the primary pain: (check all that apply): sharp/stabbing dull/aching burning throbbing
 numbness/tingling soreness stiffness Other _____
- B. Is the pain: occasional (0-25% of the time) intermittent (26-50% of the time)
 frequent (51-75% of the time) constant (76-100% of the time)
- C. Impairment: Mild (no effect on daily activities) Slight (some effect on activities)
 Moderate (significant effect on activities) Severe (unable to perform activities)
6. What increases your pain? (Circle all that apply) COUGHING SNEEZING LIFTING BENDING TWISTING
DRIVING SITTING STANDING WALKING OTHER _____
8. What decreases your pain? (Circle all that apply) REST EXERCISE SITTING STANDING LYING DOWN
HEAT COLD BRACING/TAPING STRETCHING MEDICATION OTHER _____
9. Have you ever experienced this problem before? Y N When? _____
10. List any other complaints currently bothering you, and rate your level of discomfort.

a. _____	0	1	2	3	4	5	6	7	8	9	10
b. _____	0	1	2	3	4	5	6	7	8	9	10
c. _____	0	1	2	3	4	5	6	7	8	9	10
d. _____	0	1	2	3	4	5	6	7	8	9	10

10. Have you ever been involved in an automobile accident? Y N

Explain: _____

11. Have you ever been injured at work? Y N

Explain: _____

12. List any surgeries/hospitalizations you have had: _____

13. List all medication you are currently taking: _____

14. Are there any health problems in your family? Y N

Explain: _____

15. Have you ever been to a chiropractor before? Y N

If so, who/where?: _____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (check all that apply)

- smoker
- heart attack
- stroke
- asthma
- arthritis
- gall bladder trouble
- diabetes
- glaucoma
- kidney stones
- anemia
- bloody stools
- ulcers
- headache
- difficulty with bowel movements
- cancer
- AIDS
- diverticulosis
- menstrual cramping
- gout
- dizziness
- loss of balance
- diarrhea
- fainting spells
- migraine
- shortness of breath
- chest pain
- epilepsy
- tuberculosis
- syphilis
- loss of memory
- constipation
- nausea
- general fatigue
- ears ringing
- muscles cramping
- soreness in joints
- loss of hearing
- kidney stones
- prostate trouble
- sprained ankle R L
- knee/hip replacement
- birth control pill
- difficulty with urination
- sudden weight loss/gain
- broken bones (specify) _____

General Activities (check all that apply)

- sleep on waterbed
- fall asleep in recliner/on couch
- sleep with 2 or more pillows
- sleep on stomach
- needlepoint/knitting/sewing
- play video games (_____ hrs per day)
- read in bed
- exercise (_____ days/wk)
- computer use (_____ hrs per day)
- lift weights
- swim
- watch television (_____ hrs per day)
- jog (_____ days/wk)

Please add anything else you would like the doctor to know:

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent if the patient is a minor)

Doctor's Comments: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of High Point Chiropractic's Notice of Privacy Practices for Protected Health Information, and I have been told that a copy is available at the front desk at any time.

_____ Date _____

Patient Signature

PATIENT PREGNANCY DISCLAIMER (FEMALES ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time,

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____ Date _____

Patient Signature

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are moving of bones with the doctor's hands or with the use of a machine, table, or instrument. Frequently adjustments created a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust-atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustment may also potentially be related to vertebral artery strokes, but no one is certain. One of the most recent studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. This result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise cure for any symptoms, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments and resultant nerve interference).
2. Adjustment of the spine for the purpose of correcting vertebral subluxations.
3. Education and encouragement of our patients/practice members to become aware of and responsible to their well-being.
4. Empowerment of our patient/practice members as to the inherent healing capabilities of the human body. Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I understand the practice of chiropractic as outlined, I am aware of the risks as outlined above, and wish to receive care at HIGH POINT CHIROPRACTIC for myself/my family.

Patient Signature Date _____

Authorized Provider Representative Printed Date _____

Witnessing signing of: Authorization to treat Privacy Notice Pregnancy Disclaimer Informed Consent