New Patient Paperwork

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Personal Information

Name_____ Date_____
Home Address_____ City_____ State___ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Email Address_____
Contact Pref. H_ W_ C_ Email_ Birth Date __/__/____ Age __
Marital Status (circle one) Single Married Divorced Widowed
# of Children and Ages_____
Employer_____ Occupation_____

Other Information

Emergency Contact_____ Relation_____ Phone_____
How were you referred to our office?_____
Have you ever been to a chiropractor? Y_ N_ Who?_____When_____
If yes, were the results satisfactory?_____
Long-term goal of this appointment_____

Primary Care Physician

Physician:_____ Phone:_____
May we update them on your condition? Y_ N_

Insurance Information- If insured, please provide your insurance card to copy

Relationship to insured Self___ *Spouse_____ *Parent_____
*If other than "Self" provide Name and Date of Birth of insured:
Name:_____ DOB:_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the policyholder. I authorize this office to release any medical information and to complete any usual and customary reports to assist in collecting information from my insurance company. I understand that I am ultimately responsible for payment in full at this office.

Patient's Signature _____ Date _____

INJURY INFORMATION

Describe your major complaint_____
When did your problem begin? (specific date if possible) _____
How did your problem begin? _____
_____
What increases your pain? _____ decreases? _____
How many days a week do you experience pain/discomfort? _____ days
Are your symptoms ___Decreasing ___Not Changing ___Increasing
Symptoms are worse in the __Morning ___Afternoon ___Evening ___Same all day
Has your daily activity changed as a result of your condition? If so, please explain.
No__Yes_____

PAIN CHART

Please Mark the Areas of Pain using these Symbols & Mark Severity of Pain to the Left
+++ Burning XXX Dull/Ache /// Numbness/Tingling === Throbbing 000 Stabbing/Sharp

SEVERITY OF PAIN

1. Complaint_____

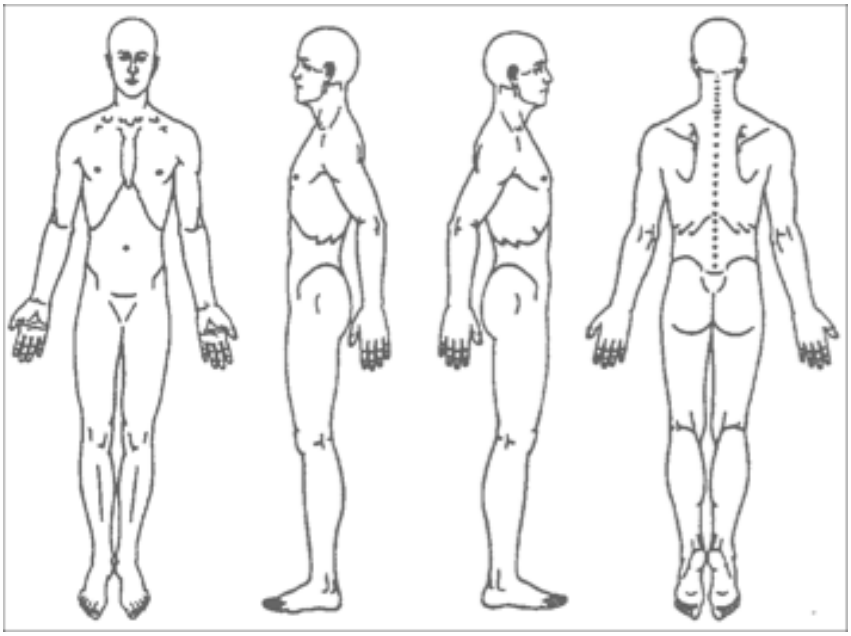
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

2. Complaint _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

3. Complaint _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable



Have you detected any possible relationship of your current complaint with any of the following:
___Bowel/Bladder problems ___Digestion ___Cardiac/Respiratory ___Other:_____

What treatments have you previously tried for this condition?
Physical Therapy ___ Chiropractic ___ Massage ___ Orthopedic ___ Family/Primary Doctor ___
Other _____
If so, please write name _____

Have you had Spinal X-Rays, MRI, CT SCAN? __No __Yes:
Date(s) taken: _____ Area(S) taken _____

Condition(s) being treated:
_____

List all prescription, non-prescription medications and other supplements you take as well associated condition:
_____
_____

List any surgeries or hospitalizations you have had including month and year:
_____
_____

Family
History:_____
_____

Do you exercise: ____Yes ____No Hours per week?____
What activities:_____

Are you dieting? ____Yes ____No Since?___

Do you smoke? ____Yes ____No Packs per day?____ How many years? ____

Do you drink alcoholic beverages? ____Yes ____No Drinks per day _____

How much water do you drink in a day? _____

Are you currently pregnant? __Y __N *Who is your current OBGYN/Mid-Wife/Doula?_____

* All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any pay- able benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature: _____ Date: _____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Rehabilitative exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as get- ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the- counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.
To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____
_____Signature of Parent or Guardian Date_____
(if a minor)

Financial/Privacy Policy & Disclaimer and Authorization

Payment

- Due at Time of Service

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a $20 charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator.

HIPAA Privacy Policy

- Available at the front desk is the HIPAA Notice of Privacy Practices Policy for you**.** By signing below, the patient acknowledges that he/she has had the HIPAA Privacy Policy made available to him/her and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate CHC to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to obtain any medical records that are pertinent to my cur- rent condition that has led me to seek care from CHC.

- You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.

_____ _____

patient signature date

Insurance Patients ONLY:

- I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.
- I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
- I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Copper Heights Chiropractic are **paid in full**.

_____ _____

patient signature date

Functional Exam

Name_____Date_____Doctor_____

Gait/Posture

ROM

MRS

Muscles

-TrP

-Weak/Inhibited

-Overactive

Motion Palpation

6 inch Step

Modified Thomas

Hip ABD

HIP EXT/Int Rot

Shoulder ABD

Quad Rock/Push-up

TMJ

Other Test (ortho/fxnal//DNS)