Patient Information Form/Update

Patient Information:

Name_____DOB_____

Parent's name if patient is under 18_____

Address_____City_____State____Zip_____

Phone Number: Cell_____Work_____

E-mail address (used for appt. reminders and emails about clinic information, never sold) _____

Type of insurance_____

Name of Insured_____DOB_____

Emergency Contact_____Relationship_____Phone_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the doctor's 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 the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. If payment is not received in 30 days after being billed by this office, a $15.00 re-billing fee is added every 30 days. Thank you.

_____

Parent/guardian print Signature Date

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor(s) to administer care to my son/daughter as they deem necessary.

_____

Parent/guardian print Signature Date

Confidential Health Questionnaire

All information will be kept strictly confidential. Your response will help determine if chiropractic treatment will benefit you.

Name_____**Date**_____

Please check the degree of all conditions which you have or have had. We need your complete health report before we can be responsible for your case.

General
_____ Allergy
_____ Dizziness
_____ Fainting
_____ Fatigue
_____ Fever
_____ Headache
_____ Loss of weight
_____ Loss of sleep
_____ Depression
_____ Numbness
_____ Sweats

Muscle/Joint
_____Arthritis
_____Bursitis
_____Low back pain
_____ Mid back pain
_____ Neck pain

Respiratory
_____ Chest pain
_____ Chronic cough
_____ Difficult breathing
_____Wheezing

Pain or Numbness
_____ Shoulders
_____ Arms
_____ Elbows
_____ Hands
_____ Hips
_____ Legs
_____ Knees
_____ Feet
_____ Painful tailbone
_____ Poor posture
_____ Sciatica
_____ Spinal curvature

Gastro-Intestinal
_____Belching or gas
_____Colitis
_____ Constipation
_____ Diarrhea
_____ Bloated abdomen
_____ Gall bladder trouble
_____ Hemorrhoids
_____ Jaundice
_____ Liver trouble
_____ Nausea
_____ Pain over stomach
_____ Poor appetite
_____ Ulcers

Cardio-vascular
_____ High blood pressure
_____ Abnormal heartbeat
_____ Swelling of ankles

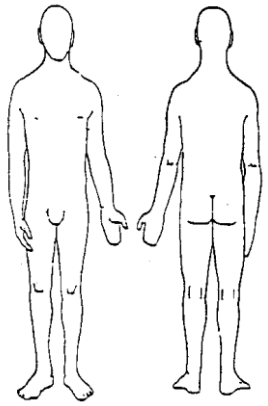
Eye, Ear, Nose & Throat
_____Asthma
_____Loss of hearing
_____Earache
_____ Sore throat
_____ Enlarged glands
_____ Nasal obstruction
_____ Nose bleeds
_____ Sinus infection
_____ Sore throat
_____ Enlarged glands

Skin
_____Bruise easily
_____Dryness
_____Hives or allergy
_____Itching
_____Skin eruptions (rash)

Genito-Urinary
_____Prostate trouble
_____Bed-wetting
_____Blood in the urine
_____Frequent urination
_____Kidney infection
_____Painful urination

Women Only
_____ Excess menstrual flow
_____ Hot flashes
_____ Irregular cycle
_____ Lumps in breast
_____ Menopause
_____ Painful menstruation
_____Abnormal vaginal discharge

Are you pregnant? No___Yes___
If yes, how long _____months
Number of children_____



Please indicate where you are having pain

Check any of the following conditions you currently have or have had

__AIDS
__Alcoholism
__Anemia
__Cancer
__Diabetes
__Eczema
__Edema
__Emphysema
__Epilepsy
__Gout
__Heart disease
__Multiple Sclerosis
__Pace maker
__Pneumonia
__Polio
__Rheumatic fever
__Stroke
__Tuberculosis

Reason for today's visit (Describe)

_____

_____

_____

How long have you had this condition?_____ Is it getting worse? Yes__ No__

What seemed to be the initial cause_____

Grade your pain (0 is no pain, 10 is the worst pain): 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (circle those that apply): sharp dull achy shooting tingling burning stabbing stinging pulling pinching

Have you seen a chiropractor before? Yes__ (If yes, how long ago?) For what reason:
No __

_____

Are you under the care of a physician? Yes __ (if yes, for what?)
No __

_____

Have you been hospitalized in the last 5 years? Yes __ No __ if yes, please describe_____

_____

Are you currently taking any medication? Yes __ No___ If yes, please list_____

_____

Please list any drug allergies:_____

Please list any other health conditions you have been treated for, or surgery you have had:_____
_____

_____

Family health info: Some health conditions are the result of hereditary spinal weaknesses. Info about your immediate family, brothers, sisters, parents, and grandparents, will give us a better understanding of your total health picture.

Relationship **Past and Present Health Problems**

_____

_____

_____

_____

Summary: (Doctor's use)

Pediatric Functional Form

Child's name:_____

Today's date:_____

Please check all those that apply to your child.

_____1. Has your child been more irritable?

_____2. Has your child had difficulty sleeping?

_____3. Has your child's sleeping pattern changed?

_____4. Has your child's digestion pattern changed (i.e. constipation/diarrhea)

_____5. Has your child's intake of food been less or more?

_____6. Has your child needed more parental attention/affection?

_____7. Has your child been more distant/less affectionate?

_____8. Has your child had trouble with learning or retaining information?

_____9. Has your child's attention or focus been shortened?

_____10. Has your child's balance or coordination been altered?

_____11. Have you noticed any changes in speech patterns?

_____12. Have you noticed any changes in breathing patterns?

_____13. Have you noticed any visional changes such as squinting?

_____14. Have you noticed a change in "playing" patterns?

_____15. Have you noticed any aggression/violence/acting out?

_____16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?

_____Score

Informed Consent

PATIENT NAME:_____ Date of Birth:_____

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment i use as a Doctor of Chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument called an Activator in order to move your joints to improve their function, alignment and reduce nearby nerve irritation. You may feel a "click" or "pop," and you may feel movement of the joints during the adjustment. Various ancillary procedures, such as massage, trigger point therapy, hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or rehab exercises may also be used to aid in treatment and to prepare your body for the adjustments.

Possible risks and probability of those risks occurring.

By any standard, chiropractic adjustment is a conservative and very safe procedure. Chiropractic, as well as all other health professions, 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 before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, I cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office.

Although generally described as rare, chiropractic adjustments and physical therapy procedures may be accompanied by post treatment soreness, disc injury aggravation, muscle strains, minor burns to the skin while receiving moist heat, rare rib injury or fracture or in very rare incidents (with high risk patients) stroke. Precautions such as pre-treatment history, examination and diagnostic x-rays as needed prior to care minimize such risks, as well as performing all treatment carefully. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform me.

Risks of remaining untreated.

Remaining untreated or delay of treatment may increase complications that include the formation of adhesions, scar tissue and other degenerative changes. These changes decrease joint motion and may lead to chronic pain. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible, but I will rely on the Doctor's training and education which she feels necessary, based on the facts and diagnosis in my case, knowing that she will act in my best interest.

Acupuncture treatment

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, during treatment, or when the needles are being removed. Unusual risks of acupuncture include lung puncture (pneumothorax) if acupuncture is performed in the region of the lung. Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify the doctor who is caring for me if I am or become pregnant. Although acupuncture is safe to use during pregnancy, there are some**

acupuncture points to be avoided in pregnancy. I will also notify the doctor if I have a bleeding disorder, if I am taking anti-coagulants or other medication.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me, the above explanation. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended realizing that no guarantees can be made regarding the outcome of treatment. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature (or Parent/Guardian) **Print name of Parent or Guardian (if a minor)**

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Gerhardson Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notices of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature (or Parent/Guardian) **Print name of Parent or Guardian (if a minor)**