Initial Health Status

Patient Name:_______________________ DOB: _______________ Sex: M F

Address: _______________________ Preferred Phone: _______________

City: _______________________ State: ____________ Zip: ____________

E-mail: _______________________

Occupation: _______________________

Will you be using insurance for this visit? Yes / No (If yes please provide insurance card to the front desk)

Primary Care Physician: _______________________

May we contact your primary care regarding this condition: Yes / No

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

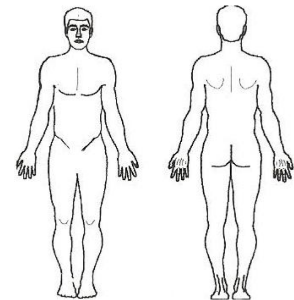
MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

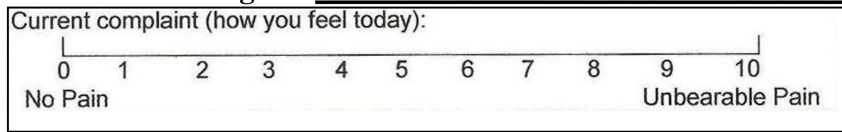
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other: _______________

Is this: ☐Work Related ☐Auto Related ☐ N/A

Date Problem Began: _______________________

How Problem Began: _______________________

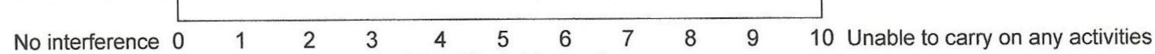




How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?



In general would you say your overall health is:

☐ Excellent ☐ Very Good ☐Good ☐ Fair ☐ Poor

HAVE YOU HAD X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐No ☐ Yes

Date(s) Taken _______________ **What Areas were taken?** _______________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐Stroke (Date) ___/___/___
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/ Fainting
☐ Numbness in Groin or Buttocks
☐ Cancer/ Tumor (Explain): _______________
____
☐ Osteoporosis
☐ Epilepsy/ Seizures
☐ Other Health Problems (Explain)
____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant
#Weeks_______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/ Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Visual Disturbances
☐ Surgeries
____
____
☐ Tobacco Use – Type
____
Frequency _______________________
☐ Medications: _______________________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify the practitioner immediately whenever I have changes in my health condition. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _______________________ Date_______________

INFORMED CONSENT

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

The Nature of the Chiropractic Adjustment: The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. We will use those procedures to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examination and treatment you are consenting to the following procedure: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies, palpation, orthopedic testing, postural analysis, hot and cold therapy, vital signs, basic neurological testing, electrical muscle stimulation, traction, decompression, exercise, and stretches

The Material Risks Inherent in Chiropractic Adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We 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 us.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options: Other treatment options for your condition may include: self – administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kevin Rose, DC or Dr. Travis Rose, DC and have had my questions answered to my satisfaction. 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. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name (print) ____

Patient's Signature ____ **Date** ________

Signature of Parent or Guardian (if a minor) ________________________**Date** ________

Authorized Facility Signature _______________________________ **Date** ________

[For Office Use Only]

Frequency of Treatment: __________________ Express: _________ Standard: _________ Extended: _________

Financial Responsibility, Assignment of Benefits, Privacy Policies

Financial Responsibility: This office files insurance claims as a courtesy to our patients. This does not relieve the patient of their financial duty. All balances are the patient's responsibility and are due at the time of services rendered. You agree that you are responsible for all charges accumulated for services rendered to you regardless of insurance payment. All co-pays, deductibles, and other charges are due at the time of service. Your account must be in good standing in order to continue with your treatment for your condition. (Emergency and life threatening conditions are exceptions).

Assignment of Insurance Benefits: I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize Provider to submit claims, on my and / or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

Acknowledgment of receipt of privacy polices: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. I acknowledge that I have received and/or had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Peak Form Health Center. I understand that the Notice describes the uses and disclosures of my protected health information by Peak Form Health Center and informs me of my rights with respect to my protected health information.

CANCELLATION POLICY

****Please be advised there is a $10 fee for 1st missed appointment, $25 for 2nd, and $50 for 3rd without 24 hour notice.**

_______________________________ ________________

Patient/Guardian/Insured Name (Print) Date

_______________________________ ________________

Patient/Guardian/Insured (Signature) Date