CHIROPRACTIC CARE - PATIENT ADMITTANCE FORM

FULL NAME ______________________________ DATE __________
APPROVED MAILING ADDRESS ______________ APT____CITY________ STATE _____ ZIP ________
APPROVED CELL PHONE # ______________ APPROVED WORK/ HOME NUMBER ______________
E-MAIL ADDRESS ______________________________
DATE OF BIRTH ____________ SEX _______ MARITAL STATUS _______SPOUSE NAME ____________
OCCUPATION ______________________ CHILDREN (AGES) ______________________
EMPLOYER ______________________ EMPLOYER ADDRESS ______________________
SOCIAL SECURITY # __ __ __-__ __ -__ __ __ __ DRIVER LICENSE # ______________ STATE ________
HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________
PREFERRED METHOD OF COMMUNICATION FOR PATIENT REMINDERS (circle one) E- MAIL / PHONE / TEXT
PREFERRED LANGUAGE: ENGLISH / SPANISH / OTHER : ______________________
RACE:American Indian or Alaska Native/Asian/ Black or African American/ White(Caucasian)/ Native hawaiian or Pacific Islander /Other / I Decline to Answer
ETHNICITY: Hispanic or Latino / Not Hispanic or Latino / I Decline to answer
NAME OF PERSONAL PHYSICIAN ______________________________
NEAREST RELATIVE NOT LIVING WITH YOU (EMERGENCY CONTACT) ______________________
RELATIONSHIP ____________ PHONE ____________ ADDRESS ______________________
WHO IS RESPONSIBLE FOR THIS ACCOUNT? ______________________________
TYPE OF PAYMENT YOU PLAN TO USE (circle one) INSURANCE / CASH / CREDIT CARD / OTHER

ACCIDENT- INJURY INFORMATION

Are your present problems due to an accident or injury? Yes / No Date of accident / injury ______________
Type of accident / injury (circle): Auto / On-The-Job / Sport / Military / Household / Slip & Fall / Personal / Other ________
Name of Attorney handling your case ______________________ Phone # ______________

INSURANCE INFORMATION

Type of insurance you plan to use to help pay your account (circle): Auto / Work Comp / Group / Medicare / Other ________
Name of Insurance Company ______________________ Phone # ______________
Insured's Name/ Date of Birth ______________ ID # ______________ Group # __________
If insurance is your spouse's please list spouse's employer:

TREATMENT AUTHORIZATION

I hereby authorize this office and its staff and doctors to examine and treat me or my above mentioned dependents condition as the doctor deems appropriate and I give authorization for these procedures to be performed. I clearly understand and agree that all services rendered to me or my dependent(s) are charged directly to me and that I am responsible for payment of service by this office and all outside laboratory or radiology service performed on me or my dependents behalf. Should collection of a past due amount become necessary, I will become responsible for all charges, fees and attorney fees. All charges for services and care given will be charged directly to me and I will be personally responsible for payment of them. If I have insurance that covers care I am assigning my benefits to this office if they're an in network provider. I also authorize them to send my records to my insurance company if needed. I give permission to be called by telephone concerning me or my dependent(s) appointment or treatment, even if my name and number are on a state or national do not call list. Please also be aware we do use audio and video recording throughout this office. We realize today's spinal exam includes,but is not limited to a consultation, history of complaint and examination / palpation of the area involved to determine if there is a need for chiropractic care. We require by law to advise you of the fees for our services. They are as follows: x-ray 8 x10-view $30 each; 14x17-view $45 each; copies of x-ray CD $10; Spinal manipulation $70; Shockwave $100; Acupuncture $100; all remaining therapies $50 each. Please rest assured our staff/ manager will go over any cost before doing any charged procedures.

Can we use your last name for in-office promotions? Yes / No
Patient / Guardian Signature (x) ______________________________ Date ______________

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

***Over-the-counter analgesics.** The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.

***Medical care.** Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

***Hospitalization.** In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

***Surgery.** In conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I have read or have had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Patient Name	Signature	Date
Witness Name	Signature	Date

HEUSER CHIROPRACTIC,P.C.
1356 N ACADEMY BLVD
COLORADO SPRINGS CO 80909

719-574-6006

(Consent to use PHI) Notice of Privacy Practices- Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by HEUSER CHIROPRACTIC,P.C. or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice Of Privacy 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 restrictions will be binding with this office. Use or disclosure of protected Information in violation of an agreed upon restriction will be a violation of 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.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Date
Witness Signature	Date

HIPPA Acknowledgement & Consent

Patient Health Questionnaire-PHQ

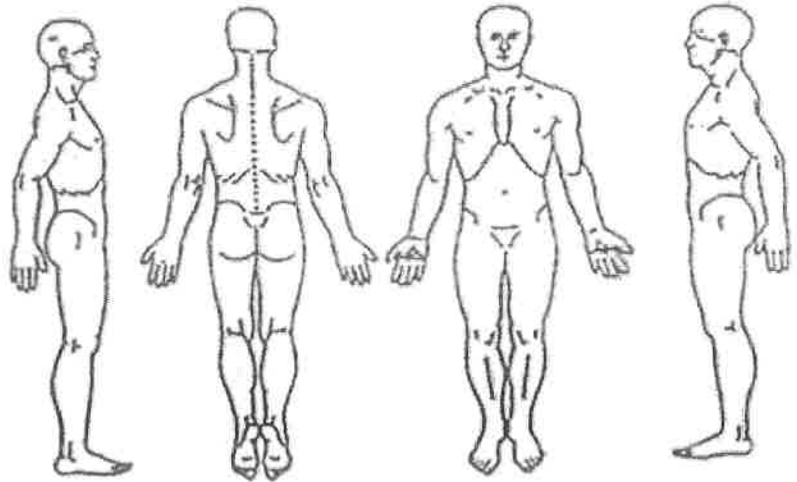
Patient Name: ______________________________ Date: ______________

1. Describe your symptoms: ______________________________

a. When did your symptoms start? ______________________________

b. How did your symptoms start? ______________________________

2. **How often do you experience your symptoms? Indicate where you have pain or other symptoms:**
   1. Constantly (76-100% of the day)
   2. Frequently (51-75% of the day)
   3. Occasionally (26-50% of the day)
   4. Intermittently (0-25% of the day)



3. **What describes the nature of your symptoms?**
   1. Sharp
   2. Dull ache
   3. Numb
   4. Shooting
   5. Burning
   6. Tingling

4. **How are your symptoms changing?**
   1. Getting Better
   2. Not Changing
   3. Getting Worse

5. **During the past 4 weeks:**

   None — Unbearable

   a. Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 10

   b. How much has pain interfered with your normal work? (including both work outside the home, and housework)

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. **During the past 4 weeks how much of the time has your condition interfered with your social activities?** (like visiting with your friends, relatives, etc)

   1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

7. **In general would you say your overall health right now is…**

   1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

8. **Who have you seen for your symptoms?**

   1. No One 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

   a. What treatment did you receive and when? ______________________________

   b. What tests have you had for your symptoms and when were they performed?

   1. X-rays date __________ 2. MRI date __________ 3. CT Scan date __________ 4. Other date __________

9. **Have you had similar symptoms in the past?** 1. Yes 2. No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see?

   1. This Office 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

10. **What is your occupation?**

    1. Professional/Executive 2. White Collar/Secretarial 3. Tradesperson 4. Laborer
    5. Homemaker 6. FT Student 7. Retired 8. Other: __________

    a. If you are not retired, a homemaker, or a student, what is your current work status?

    1. Full-time 2. Part-time 3. Self-employed 4. Unemployed 5. Off work 6. Other

Patient Signature: ______________________________ **Date:** ______________

PREVIOUS HEALTH PROBLEMS

PLEASE CIRCLE ALL THAT APPLY

General:
Weight loss or gain
Fatigue
Fever or Chills
Weakness
Trouble Sleeping

Skin:
Rashes
Lumps
Color Changes

Eyes:
Vision Loss/Changes
Eye Pain
Blurred Vision

Throat:
Dry Mouth
Sore Throat
Hoarseness

Respiratory:
Chronic Cough
Bronchitis
Pneumonia
Asthma
Shortness of Breath
Wheezing
Painful Breathing
Difficulty Breathing

Cardiovascular:
Chest Pain/Discomfort
Palpitations
History of Aneurysm
Heart Attack
Stroke

Gastrointestinal:
Heartburn
Nausea
Change in Bowel Habits
Constipation
Diarrhea

Urinary:
Frequency
Urgency
Incontinence
Bedwetting

Neurologic:
Dizziness
Weakness
Numbness
Tingling
Tremor
Memory Loss
Depression
Stress
Ringing in Ears

Implants:
Pacemaker
Other Electronic Implant
Joint Replacement
Metal Screws/Implant

Other Symptoms:
Headaches
Neck Pain
Tight Muscles
Muscle Spasms
Shoulder Pain
Pain Down Arm
Numbness Hands/Feet
Pain Between Shoulders
Abdominal Pain
Lower Back Pain
Hip Pain
Pain Down Legs
Knee Pain
Foot Pain/Numbness
Midback Pain

BROKEN BONES AND/OR FRACTURES: ______
HEAD TRAUMA/WHEN: ______
SURGERIES: ______
OTHER SERIOUS ILLNESS: ______

ARE YOU PREGNANT? YES OR NO
SMOKING STATUS (Circle one) EVERYDAY SMOKER / OCCASIONAL SMOKER / FORMER SMOKER / NEVER SMOKED
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please include regularly used over the counter medications)

MEDICATION NAME:	DOSAGE AND FREQUENCY (i.e. 5mg once a day, etc)

DO YOU HAVE ANY ALLERGIES?

MEDICATION NAME:	REACTION:	ONSET DATE:	ADDITIONAL COMMENTS:

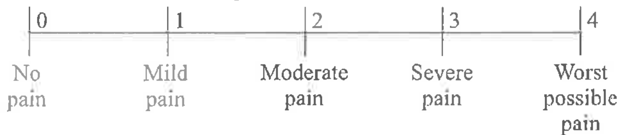
PATIENT SIGNATURE: ______ DATE: ______

Functional Rating Index

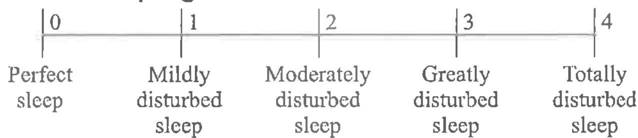
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

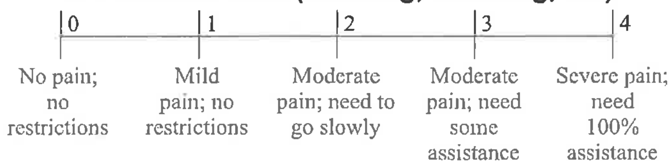
1. Pain Intensity



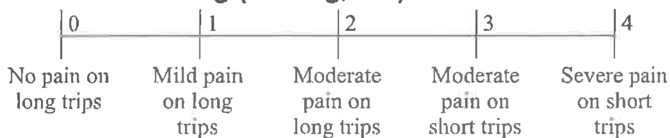
2. Sleeping



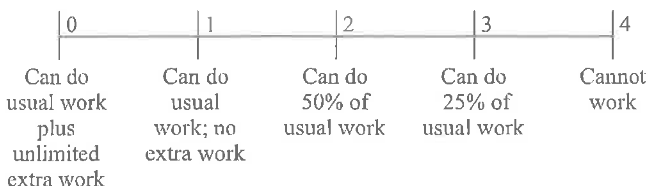
3. Personal Care (washing, dressing, etc)



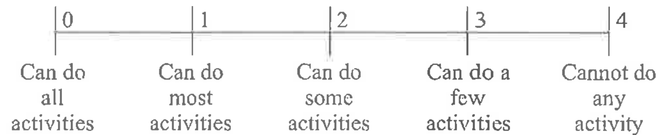
4. Travelling (driving, etc)



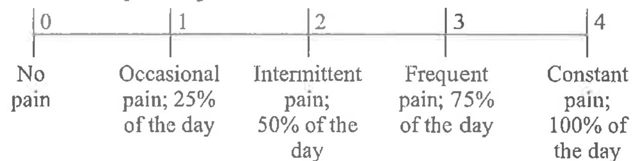
5. Work



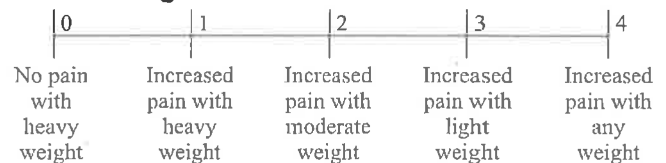
6. Recreation



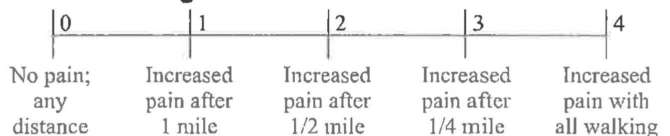
7. Frequency of Pain



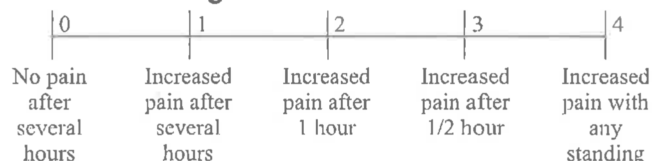
8. Lifting



9. Walking



10. Standing



Patient's Signature ______________________

Date ______________________

For Office Use Only:

Clinical Diagnosis Codes:

Practitioner ID#: ______________________

Patient ID#: ______________________

Total Score ______________ **/ 40**