DYNAMIC SPINE
Chiropractic Health Center

Patient Information

*Name_____ *Today's Date_____*
Birthdate_____

*Address_____ *City_____ *State_____ *
Zip_____

*Home Phone_____ *Cell Phone_____ Work Phone_____

*Gender __M __F Social Security Number_____

Significant Others Name _____

Kids Names and ages_____

Your Employer_____ Type of Work_____

Email Address_____ Name of Medical Doctor_____

*Emergency Contact_____ *Relationship to Patient_____

Who may we thank you for referring you to this office?_____

Family Health History

Please check the appropriate boxes

Your Employer:_____

Condition	SPOUSE	CHILD	SIBLING	MOTHER	FATHER	GRANDPARENT
Headaches						
Neck Pain						
Scoliosis						
Jaw Pain						
Back Pain						
Arthritis/Joint Pain						
Fatigue						
Anxiety						
Allergies						
High/Low Blood Pressure						
Sciatica						
Fibromyalgia						
Poor Posture						
Stroke						
Cancer						
Heart Disease						
Diabetes						
Migraines						

I hereby authorize payment to be made directly to Dynamic Spine Chiropractic Health Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Dynamic Spine Chiropractic Health Center for any and all services I receive at this office.

_____

*Patient or Authorized Person's Signature

_____ ____-____-____

*Patient Name *Date Completed

_____ ____-____-____

Name:_____

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Acknowledgements

*Initials_____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

*Initials_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____

*Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

*Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

*Initials_____ I may request a copy of the Financial Policy at any time.

*Initials_____ I authorize my insurance company or administrator to pay Dynamic Spine Chiropractic Health Center P.C. directly for the benefits otherwise payable to me under my current policy.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

***Signature:**_____* ***DATE:**_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights or privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

I have reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

***SIGNATURE:**_____ * **DATE:**_____

If the patient is a minor child, please print the child's full name:_____

Witness_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

*Patient Name:_____ * Signature:_____ *Date:_____
*Parent or Guardian:_____*Signature:_____* Date:_____
Witness Name:_____ Signature:_____ Date:_____

Doctor’s Signature: _____ Date Completed: _____

Name:_____ Date:_____

REVIEW OF SYSTEMS

PAST PRESENT

Musculoskeletal

- ○ ○ Back Problems
- ○ ○ Neck Problems
- ○ ○ Scoliosis
- ○ ○ Arthritis
- ○ ○ Joint Problems
- ○ ○ Osteoporosis
- ○ NONE

Neurological

- ○ ○ Dizziness
- ○ ○ Anxiety/Depression
- ○ ○ Weakness
- ○ ○ Headache
- ○ ○ Numbness/Tingling
- ○ NONE

Cardiovascular

- ○ ○ High Blood Pressure
- ○ ○ High Cholesterol
- ○ ○ Heart Disease
- ○ ○ Poor Circulation
- ○ ○ Chest Pain (Angina)
- ○ NONE

Respiratory

- ○ ○ Asthma
- ○ ○ Pneumonia
- ○ ○ Seasonal Allergies
- ○ ○ Shortness of Breath
- ○ ○ Sleep Apnea
- ○ ○ Emphysema
- ○ NONE

Digestive

- ○ ○ Food sensitivities
- ○ ○ Kidney Stones
- ○ ○ Heartburn
- ○ ○ Constipation/Diarrhea
- ○ NONE

Men

- ○ ○ Prostate Problem
- ○ ○ Erectile Dysfunction
- ○ NONE

PAST PRESENT

Women

- ○ ○ PMS
- ○ ○ Infertility
- ○ ○ Currently Pregnant
- ○ ○ Nursing
- ○ NONE

Constitutional

- ○ ○ Fatigue
- ○ ○ Weakness
- ○ ○ Poor Appetite
- ○ ○ Sudden Weight change
- ○ ○ Blood sugar Problems
- ○ NONE

Past Medical History

Illnesses

- ○ Epilepsy
- ○ Cancer
- ○ Diabetes
- ○ Stroke
- ○ Multiple Sclerosis
- ○ Shingles
- ○ Heart Disease
- ○ Other:_____
- ○ NONE

Social History

Alcohol Use

○ Excessive ○ Social ○ None

Recreational Drug Use

○ Yes ○ No

Exercise

○ Daily ○ Weekly ○ Never

Tobacco Use

○ None ○ Smoke ○ Smokeless

Diet Quality

○ Good ○ Fair ○ Poor

Soft Drinks

○ Daily ○ Weekly ○ Never

Coffee

○ Daily ○ Weekly ○ Never

Stress

○ Mild ○ Moderate ○ Severe

PAST HEALTH HISTORY

Check any that apply

- ○ Broken bones ○ Disability
- ○ Dislocations ○ Tumors
- ○ Heart Attack ○ Fracture
- ○ Osteo-Arthritis
- ○ Rheumatoid Arthritis
- ○ Cerebral Vascular

List Any Prescriptions you currently take:

_____
_____
_____
_____
_____
○ NONE

List Any Allergies to Medications:

_____
_____
_____
_____
○ NONE

List any Supplements you take:_____
_____
_____
_____
○ NONE

List any past Injuries/Surgeries:

_____
_____
_____
_____
○ NONE

List any past diseases/illnesses:

_____
_____
_____

Doctor Initial:_____