Foundation Health & Wellness

Date _____ **Provider being seen by** _____

Last Name_____ First:_____Middle:_____

Address:_____City:_____ Zip:_____Birthdate:_____Age:____

Email:_____ Phone:_____

Text Reminders? ❑ Yes ❑ No If yes, Phone Service Provider: _____

Marital: M S W D Spouse's Name:_____Are you pregnant? ❑ Yes ❑ No If Yes Due Date:_____

Children's Names and Ages:_____

Have your children been under previous chiropractic care? ❑ Yes ❑ No

Occupation:_____Employer_____Phone:_____

Emergency Contact _____ Phone Number _____

Whom may we thank for referring you: _____

Prior Chiropractic Care:

Doctor's Name_____Clinic Name:_____Phone:_____

For how long:_____Results Achieved: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

X-rays taken: ❑ Yes ❑ No If so, When:_____What areas:_____

Medical Doctor:

Doctor's Name_____Clinic Name:_____Phone:_____

Doctor's Name_____Clinic Name:_____Phone:_____

Other Healthcare Providers:

Doctor's Name_____Clinic Name:_____Phone:_____

Reason(s) for Visit:_____

When did you first start noticing this?_____Cause?_____

How often does this occur?_____

Is the symptom interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____

Other Doctors seen for this reason?_____

What medications are you taking?_____

Have you had surgery? ❑ Yes ❑ No What?_____When?_____

Office Use

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

OTHER

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

PLEASE PRINT

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable
Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports
Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____
Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____
Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	

YOUR GOALS FOR CARE:

☐ Feel better quickly/pain relief.
☐ Feel better soon and prevent its return.
☐ Have a healthier spine
☐ I want optimum health and to live a healthier lifestyle.

How would you rate your overall health?

Worst you have ever been — Best you have ever been

Please place an X on the line where you perceive you are overall.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between out team and yourself. Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with our office.

Clients Signature_____Date:_____

INFORMED CONSENT TO EVALUATION AND TREATMENT

PATIENT NAME _____

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 if there is anything that is unclear.

The nature of the chiropractic treatment.

The primary treatment used by doctors of chiropractic is the spinal adjustment
The Doctor will use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click." You may feel or sense movement with the procedure.

The material risks inherent in chiropractic treatment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic treatment. The most common complication(s) will be feeling some stiffness and soreness following the first few days of treatment. This is normal. Rare complications include muscle sprains and ligament strains, costovertebral strains and separations, fractures, disc injuries, dislocations, Horner's syndrome, and cervical myelopathy. Some types of manipulation of the neck have been associated with pre-existing injuries to the arteries in the neck contributing to serious complications including stroke. The Doctor 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 the Doctor's attention, it is your responsibility to inform the Doctor.

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 examination and radiographic studies. Stroke has been the subject of ongoing research and debate. The most recent research is inconclusive as to a specific incident of this complication occurring with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. Unfortunately, there is no one recognized screening procedure to identify patients with neck pain who are at risk for complicating a pre-existing arterial injury leading to stroke.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

1. Vital Signs
2. Range of Motion Testing
3. Muscle Strength Testing
4. Spinal Palpation
5. Spinal Thermography
6. Basic Neurological Testing
7. Postural Analysis
8. Orthopedic Testing
9. Radiographic Studies
10. Spinal Adjustments
11. Manual Reflex Stimulation
12. Myofascial Release
13. Mechanical Traction
14. Nutritional Testing
15. Exercise Recommendation

The availability and nature of other treatment options.

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- Hospitalization with traction
- Surgery

If you choose to use one of the "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 medical physician.

The material risks inherent in such options and the probability of such risks occurring include:

- Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's

discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

- Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize the consulting doctor of chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor child named above. (If applicable) Under the terms and conditions of a divorce, separation or other legal authorizations, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

I have **read** or have **had read** to me the above explanation of the chiropractic adjustment and related treatment. I have had the opportunity to discuss it with the consulting doctor and have had my questions (if any) answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the benefits and the risks, I hereby give my consent to that treatment.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

WITNESSES

_____
Printed Name

_____
Signature

Patient Health Information Consent Form

=You May Refuse to Sign This Acknowledgement=

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If **you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information we encourage you to read the HIPAA NOTICE that is available to you by request before signing this consent.**

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient's PHI will not be shared with any 3rd party or individual unless consent is given below.
5. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

{Please Print Name} {Signature}

_____ _____

{Date} {Please release my PHI to the above person(s)}

For Office Use Only

We attempted to obtain written consent of our Notice of Privacy Practices, but consent could not be obtained because:

D Individual refused to sign ☐ Communications barriers prohibited obtaining consent

D An emergency situation prevented us from obtaining consent D Other (Please Specify)_____