Walk-In Chiropractic
Confidential Health History

Name:_____ **Home Phone:**_____

Address:_____ **Cell Phone:**_____

City:_____ **State:**_____ **Date of Birth:**_____

Zip Code:_____ **Sex:** M or F or other

Marital Status: M S W D

Employer:_____ **Work Location:**_____

Occupation:_____ **Work Phone:**_____

_____

Please describe your health problem: _____

_____

_____

List any other doctors seen for this problem:

_____

_____

List any diagnosis and/or treatments: _____

_____

_____

List any unusual diseases and year or occurrence/diagnosis:

_____

_____

Have you been treated for any health condition in the past year?

_____

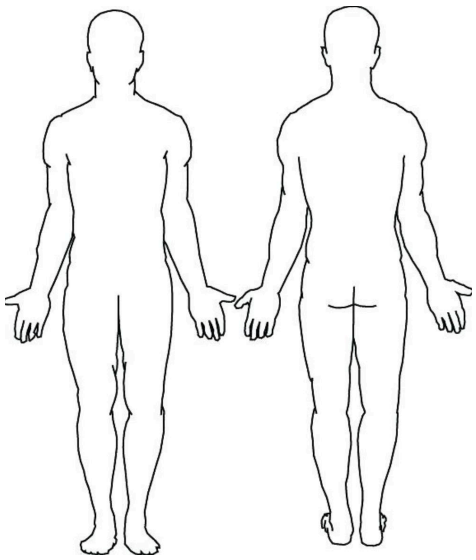
_____

Have you received chiropractic treatment previously? If yes, explain:

_____

_____

_____



Please mark your areas of pain on the figures to the left.

Rate and describe your pain for each area on a scale from 0-10, 0 being none and 10 being the worst.

_____ **sharp/stabbing dull/ache tingling numbness**

_____ **sharp/stabbing dull/ache tingling numbness**

_____ **sharp/stabbing dull/ache tingling numbness**

Please circle the condition(s) you are now having and those you frequently have.

Musculo-Skeletal	Nervous System	Cardiovascular System
Low Back Problems	Numbness	Chest Pain
Pain between Shoulders	Loss of Feeling	Pain over heart
Neck Problems	Paralysis	Difficulty Breathing
Arm Pain	Dizziness	Persistent Cough
Leg Problems	Fainting	Coughing Phlegm
Swollen Joints	Headaches	Coughing Blood
Painful Joints	Muscle Spasm	Rapid Heartbeat
Stiff Joints	Convulsions	Blood Pressure Problems
Sore Muscles	Forgetfulness	Heart Problems
Weak Muscles	Confusion	Lung Problems
Walking Problems	Depression	Varicose Veins
Broken Bones		

Please circle the condition(s) you are now having and those you frequently have.

Gastro-Intestinal	Genito-Urinary System	Eye. Ear, Nose and Throat
Poor Appetite	Bladder Trouble	Eye Strain
Excessive Hunger	Excessive Urine	Eye Inflammation
Difficulty Chewing	Scanty Urination	Vision Problems
Difficulty Swallowing	Painful Urination	Hearing Loss
Excessive Thirst	Diarrhea	Ear Discharge
Nausea	Constipation	Nose Pain
Vomiting Food	Black Stool	Nose Bleeding
Vomiting Blood	Bloody Stool	Nose Discharge
Abdominal Pain	Hemorrhoids	Difficulty breathing through Nose
Liver Trouble		Dental Problems
Gallbladder Problems		Sore Mouth
Weight Trouble		Sore Throat
		Difficulty with Speech
		Ear Pain
		Tinnitus (ringing in ears)

·–

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Please list ALL surgeries	Year of Surgery

Please any allergies to food, medication and other factors

Please list any supplements and dosages	

Do you exercise regularly? Please list what type and how often.	

Smoking Status:
Please check one:

____ Never a smoker

____ Current everyday smoker_____packs per day

____ Current periodic smoker. How often_____

____ Former Smoker. Quit in_____year.

How many Children do you have? _____

Do you drink alcohol?_____drinks per day/month (please circle)

Caffeine? How often?_____How much? _____
What kind of caffeine (circle)? Coffee Soda Tea

Current Medications	**Dosage**

Signature _____

Date_____

HIPAA Acknowledgement of Receipt of Notice of Walk-in Chiropractic's Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that Walk-in Chiropractic's ("Practice") or its Business Associates may use or disclose your Protected Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Walk-in Chiropractic's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Walk-in Chiropractic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understood and agreed to the Notice of Privacy Practices of Walk-in Chiropractic's, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

Patient

By:_____Date: _____

Print Name _____

OR, ON BEHALF OF PATIENT

By:_____Date: _____

Print Name _____

Walk-in Chiropractic and Massage LLC
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Walk-in Chiropractic and Massage LLC ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Walk-in Chiropractic and Massage LLC doctors to make those decisions about my care based on the facts they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provide me with a current fee schedule).

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. 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. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care, and drugs such as anti-inflammatories, muscle relaxants, painkillers, hospitalization, or surgery. If one chooses to use one of the above-noted "other treatment" options, one should be aware of the risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers of remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent that applies to all contemplated procedures. I have discussed all of the above risks and benefits with the practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case. I understand and accept that:

1. l have the right to withdraw from or discontinue any treatment at any time, and the Practice doctors will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor medicine is an exact science, and my care may involve making judgments based on the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The practice does not guarantee results concerning any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand the care and treatment l may receive to my satisfaction. My signature below acknowledges my consent to the practice's examination, evaluation, and proposed course of care and treatments.

_____
Witness

_____
Patient's Printed Name

_____
Patient's Signature

_____
Signature of Doctor

EMERGENCY CONTACT INFORMATION

Information about you, your appointment time or your examination results cannot be disclosed to persons other than you, unless you authorize us to do so. If you wish to disclose information to persons other than you, please indicate who they are below.

NAME	Relationship	Telephone Number

Signature:_____

Date:_____