CONFIDENTIAL PATIENT FORM

PATIENT INFORMATION

Name (First, MI, Last) _____ Gender ( ) M ( ) F Sex at Birth ( ) M ( ) F

Address_____ City/State_____ Zip_____

Cell Phone_____ Home Phone_____ Date of Birth_____

*Email Address_____

Occupation_____ Employer_____ Work Phone_____

Employer's Address_____

Married ( ) Y ( ) N Name of Spouse/ Guardian _____

COLLEGE STUDENTS

Please provide us with your parents' information.

Name_____ Phone_____

Address_____

City/State/Zip_____

REFERRED BY

How did you find us? Please circle one:

Family/Friend_____

Internet/Other_____

Acknowledgement of Receipt of Notice of Privacy Practice

This is to acknowledge receipt of a copy of **Westside Chiropractic Clinic's** Notice of Privacy Practice HIPPA with an effective date of 05/01/13.

Signature: _____ **Date:** _____

PATIENT RESPONSIBILITY AND INSURANCE POLICIES

I understand that I will be responsible for the payment of any non-covered services, deductibles, co-pays and co-insurance. I also understand that the final determination of benefits are made by my insurance payer. While my benefit may include a set number of visits or dollar amount, all care will be based on medical necessity. While every effort is made to ensure the accuracy of my benefit information, it is the patient's responsibility to be aware of their benefit coverage. All cash patients are responsible for their costs on the day of service. It is also the patient's responsibility to keep track of dates and times of service.

I authorize my insurance company to send all my payments directly to Westside Chiropractic Clinic. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company.

I understand and agree that I will present all insurance information and all insurance cards to the staff, even if my primary insurance does not cover chiropractic care. In some instances we will not bill secondary insurances. If my insurance is Medica, Health Partners, Cigna or Great West, I understand that this office has only 10 days from the date of my visit to get an authorization from my insurance company for my chiropractic care. Please keep in mind that it does take up to 90 days for the insurance companies to process and pay on your claims and you will not be billed until after this process is complete.

I understand that all accounts with outstanding balances over 60 days will be subject to the following: personal insurance or cash accounts will be billed a 1.5% service charge per month; worker's compensation or personal injury accounts will be billed a 1% service charge per month.

Patient's Signature:_____ **Date**:_____

Health Questionnaire

Patient Name:_____ **Date:** _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
o	o	Headaches
o	o	Neck Pain
o	o	Upper Back Pain
o	o	Mid Back Pain
o	o	Low Back Pain
o	o	Shoulder Pain
o	o	Elbow/Upper Arm Pain
o	o	Wrist Pain
o	o	Hand Pain
o	o	Hip/Upper Leg Pain
o	o	Knee/Lower Leg Pain
o	o	Ankle/Foot Pain
o	o	Jaw Pain
o	o	Joint Swelling/Stiffness
o	o	Arthritis
o	o	Rheumatoid Arthritis
o	o	General Fatigue
o	o	Muscular Incoordination
o	o	Visual Disturbances
o	o	Dizziness

Past	Present	
o	o	High Blood Pressure
o	o	Heart Attack
o	o	Chest Pains
o	o	Stroke
o	o	Angina
o	o	Kidney Stones
o	o	Kidney Disorders
o	o	Bladder Infection
o	o	Painful Urination
o	o	Loss of Bladder Control
o	o	Prostate Problems
o	o	Abnormal Weight Gain
o	o	Loss of Appetite
o	o	Abdominal Pain
o	o	Ulcer
o	o	Hepatitis
o	o	Liver/Bladder Disorder
o	o	Cancer
o	o	Tumor
o	o	Asthma

Past	Present	
o	o	Diabetes
o	o	Excessive Thirst
o	o	Frequent Urination
o	o	Smoking/Tobacco Products
o	o	Drug/Alcohol Dependence
o	o	Allergies
o	o	Depression
o	o	Systemic Lupus
o	o	Epilepsy
o	o	Dermatitis/Eczema/Rash
o	o	HIV/AIDS

Females Only

o	o	Birth Control Pills
o	o	Hormonal Replacement
o	o	Pregnancy

Other Health Problems/Issues

o	o	
o	o	
o	o	

Indicate if an immediate family member has had any of the following:

o Rheumatoid Arthritis o Heart Problems o Diabetes o Cancer o Lupus o Other_____

List all surgical procedures you have had and the approximate year performed:

_____

_____

_____

Patient Signature_____ **Date**_____

For office use only

Height: _____ **Weight:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

Westside Chiropractic Clinic - Informed Consent to Treatment

PATIENT NAME: _____

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 if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my 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 procedures:
_x_ spinal manipulative therapy _x_ palpation _x_ vital signs
_x_ range of motion testing _x_ orthopedic testing _x_ basic neurological
_x_ muscle strength testing _x_ postural analysis testing
_x_ ultrasound _x_ hot/cold therapy _x_ EMS
_x_ radiographic studies
___ Other (please explain)

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 strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including vertebral artery dissection or 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 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 x-ray. Vertebral artery dissection and/or stroke, if caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Serious complications occur at a rate of 1 in 2 million to 1 in 5.8 million treatments. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery injury.

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
- Surgery

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may make your problem worse. 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 UNDERSTAND 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 *Westside Chiropractic* 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.

Dated: _____

_____ _____
Signature **Signature of Parent or Guardian (if a minor)**