ALDAY CHIROPRACTIC

CHART NUMBER _____ X-RAYS TAKEN? YES or NO DATE_____

PLEASE COMPLETE THIS FORM

CONFIDENTIAL CASE HISTORY SHEET

Name_____ **REFERRED by _____

Address _____ City _____ State ____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Date of Birth _____ Age _____ Social Security NO. _____

Email Address _____ NO. Of Children _____

Place of Employment _____ Occupation _____

Marital Status: S M D W

Spouse's Name _____ Employer _____

Emergency Contact _____ Phone Number _____

Relationship _____

Reason for Visit _____

When did the symptoms first appear? _____

On a scale of 1-10 (10 being the worst), how do you feel now? **1 2 3 4 5 6 7 8 9 10**

Is the problem getting: **Better** **Worse** **Same** **Comes and Goes**

Does the problem interfere with: **Normal Living** **Hobbies** **Work**

Type of pain (circle all that apply)

Throbbing **Numbness** **Aching** **Burning** **Shooting** **Sharp**

Dull **Tingling** **Stiffness** **Swelling** **Cramps** **Other:** _____

List any Hospitalizations and dates**:** _____

_____

List any Medication currently using**:**

_____

_____

Name of family physician? _____

Past history operations _____

Do you suffer from any condition other than that which you are consulting us? Y or N

If YES, what? _____

Ever had Chiropractic care before? Y or N

If YES, Doctors name and when _____

*Below is a list of problems, which may seem unrelated to the purpose of your appointment. However as Chiropractic is a holistic health profession (caring for the entire body) these questions must be answered carefully as these problems can affect your overall course of Chiropractic care. Place a check mark by any of the following you have experienced***:**

	Pneumonia		**Muscle Cramps**		**Leg/Knee/Ankle Pain**
	Short of Breath		**Fibromyalgia**		**Jaw Pain**
	Diabetes		**Neurological Disorder**		**Neck Pain**
	Arthritis		**Numbness**		**Radiating Pain**
	Epilepsy		**Cold/Tingling**		**Buttock Pain**
	Allergies		**Heartburn/Indigestion**		**Shoulder/Arm Pain**
	Stress		**Nausea/Vomiting**		**Upper/Mid Back Pain**
	Lack of Sleep		**Vomiting Blood**		**Low back Pain**
	Head Trauma		**Abdominal Cramps**		**Liver Problems**
	Paralysis		**Stomach/Intestinal**		**Gallbladder Problems**
	Stroke		**Diarrhea**		**Kidney Problems/stones**
	Fatigue		**Constipation**		**Weight Problems**
	Dizziness		**Excessive Thirst**		**Kidney Disease**
	Vertigo		**Painful Urination**		**Heart Disease**
	Headache		**UTI**		**Thyroid Disease**
	Nervousness		**Fainting**		**High Blood Pressure**
	Gout		**Fever**		**Skin rash/Disorder**
	Cancer		**Fractures/Dislocations**		**Past Accident/Injury**

INSURANCE INFORMATION

Name of Primary Insurance Company _____

Name of Insured _____ **DOB of Insured** _____

Although this office does file insurance, it is important for you to understand that you, the patient are responsible for all outstanding changes in this office. Coverage for Chiropractic benefit is different with every insurance company and in the event that your insurance does not cover the care, we can work out different payment arrangements.

Authorization and Assignment:

I authorize the Doctor and staff of Alday Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby released the office of any consequence thereof. I agree that a photo static copy shall serve as the original.

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebted to the assignee; I agree that a photo static copy of this agreement shall serve as the original.

I understand in the event my unpaid balance has to be turned over to a collections service by Alday Chiropractic, the unpaid balance will INCREASE by 30%, to cover the collection fees.

_____ _____ _____

Signature **Witness** **Date**

Heath Care Authorization Form

Patient Name: _____ Date of Birth: _____

The patient identified about authorizes ALDAY CHIROPRACTIC to use and/or disclose protected health information in accordance with the following:

Specific Authorizations

- I give permission to Alday Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternative or other health related information.
- If Alday Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

Open Room Authorization

- I give Alday Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Alday Chiropractic permission to use and disclose your protected health information in accordance with the directive listed above.

Expiration

The authorization shall expire on the following date: As long as Patient is ACTIVE in office.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or have delivered a written notice to the Privacy Official of Alday Chiropractic. The written contain the following information:

The revocation is not effective until it is received by the Privacy Official.

Alday Chiropractic requests this AUTHORIZATION for its own use/disclosure of PHI.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Alday Chiropractic will not refuse to provide treatment.

You have the right to request or copy the Personal Health Information to be used and/or disclosed.

_____ _____ _____

PRINTED NAME OF PATIENT **SIGNATURE OF PATIENT** **DATE**

Signature of personal representative
Description of Representative's Authority to Act for Patients
*****A copy of the signed authorization can be provided to you**

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 fell a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may fell movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic adjustment. 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 even notice stiffness or soreness after the few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complication.

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 further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare’.

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

- Over-the-counter analgesics. The risk of these medications includes irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risk of these drugs includes a multitude of undesirable side effects and patient dependence in significant number of cases.
- Hospitalization in conjunction with medical care adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in significant number of cases.

Risk 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.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read 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.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date