CONFIDENTIAL PATIENT HISTORY

Name______________________________ Age__________ Date______________

Address______________________________ City______________ State________ Zip________

Home Phone (____)______________ Date of Birth____/____/____ Sex: M F Marital Status: S M D W # Children______

Occupation______________ Employer______________________ Work Phone (____)__________

Cell Phone (____)______________ E-mail______________ Insured's Name______________

Insured's Date of Birth____/____/____ Spouse's Name______________ Spouse's Occupation______________

Spouse's Employer______________________ Spouse's Work Phone (____)__________

Referred by______________________ Past Chiropractic Care ❑ Yes ❑ No When______________

Chiropractor's Name______________________ Results______________________

Nearest relative not living with you______________ Emergency contact/number______________

Insurance Company______________________ Insurance Company Phone (____)__________

Social Security #______-______-______ Driver's License #______________

Are your present problems due to an injury? ❑ Yes ❑ No ❑ On the Job ❑ Auto Accident ❑ Other ______________

If this is due to an accident, has the accident been reported? ❑ Yes ❑ No ❑ Employer ❑ Auto Insurance Carrier ❑ Other__________

Is this injury case still open? ❑ Yes ❑ No ❑ Unsure

Are you now or have you ever been under disability? ❑ Yes ❑ No Have you retained an attorney? ❑ Yes ❑ No

Attorney's Name______________________ Atty. Location/Phone______________________

List Current Problems(s)

1.______________________ Duration (How long)__________ (This episode) Previous Episodes Y/N When__________

2.______________________ Duration (How long)__________ Previous Episodes Y/N When__________

3.______________________ Duration (How long)__________ Previous Episodes Y/N When__________

❑ Additional (check here, write on back of this page)

Please mark the intensity of your pain today

0 – No Pain 10 – Excruciating Pain

	Neck (symptom)										
Example:	0	1	2	3	(4)	5	6	7	8	9	10
1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10
4.	0	1	2	3	4	5	6	7	8	9	10
5.	0	1	2	3	4	5	6	7	8	9	10

Please circle area and type of pain on the drawings using the code listed below

N – Numbness P – Pain
T – Tingling A - Ache
S – Soreness ST - Stiffness
MSP – Muscle Spasm

RIGHT LEFT LEFT RIGHT

Habits

❑ Smoking Packs/Day______ ❑ Alcohol Amt/Wk______

❑ Coffee Cups/Day______ ❑ Soda Cans/Day______

❑ Eating Habits (Describe)______________________________

____

Exercise

❑ None ❑ Health Club

❑ Moderate ❑ At Home

❑ Daily ❑ Other__________

Type______________

Family History of Illnesses

	Diabetes	Heart	Cancer	Headaches	Neck Pain	Back Pain	Other	Deceased
Mother (Age______)	❑	❑	❑	❑	❑	❑	❑	❑ Age______
Father (Age______)	❑	❑	❑	❑	❑	❑	❑	❑ Age______
Brother (# of ______)	❑	❑	❑	❑	❑	❑	❑	❑ Age______
Sister (# of ______)	❑	❑	❑	❑	❑	❑	❑	❑ Age______

Please check the correct box for each item below. ☐ Past (more than one year ago); ☐ Current (less than one year ago).

GENERAL SYSTEMS (Past / Current)

- ☐ ☐ Memory Loss
- ☐ ☐ Chills
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Fatigue (General/Muscular)
- ☐ ☐ Fever
- ☐ ☐ Headache
- ☐ ☐ Loss of Sleep
- ☐ ☐ Hernia
- ☐ ☐ Anxiety
- ☐ ☐ Mood Changes
- ☐ ☐ Irritability

GASTRO-INTESTINAL (Past / Current)

- ☐ ☐ Poor Appetite
- ☐ ☐ Excessive Hunger/Thirst
- ☐ ☐ Heartburn
- ☐ ☐ Belching or Gas
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Ulcers
- ☐ ☐ Intestinal Problems
- ☐ ☐ Poor Digestion
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Hemorrhoids

CARDIO-VASCULAR (Past / Current)

- ☐ ☐ High/Low Blood Pressure
- ☐ ☐ Angina
- ☐ ☐ Poor Circulation
- ☐ ☐ Light Headed (Positional)
- ☐ ☐ Rapid Heartbeat
- ☐ ☐ Slow/Shortness of Breath
- ☐ ☐ Chest Pain
- ☐ ☐ Strokes
- ☐ ☐ Heart Attack
- ☐ ☐ Swelling Ankles
- ☐ ☐ Varicose Veins
- ☐ ☐ Pacemaker

SKIN (Past / Current)

- ☐ ☐ Tattoo/Piercings
- ☐ ☐ Moles
- ☐ ☐ Boils
- ☐ ☐ Bruising Easily
- ☐ ☐ Dryness
- ☐ ☐ Eczema/Psoriasis
- ☐ ☐ Hives
- ☐ ☐ Itching
- ☐ ☐ Sensitive Skin
- ☐ ☐ Skin Eruptions
- ☐ ☐ Rashes
- ☐ ☐ Sweating

SPINE (Past / Current)

- ☐ ☐ Jaw Pain/Click (TMJ) R / L
- ☐ ☐ Neck Pain/Stiffness R / L
- ☐ ☐ Upper Back Pain R / L
- ☐ ☐ Mid Back Pain R / L
- ☐ ☐ Lower Back Pain R / L
- ☐ ☐ Numbness, Tingling or Pain in Buttocks, Legs, Thighs, Feet, Toes R / L
- ☐ ☐ Numbness, Tingling or Pain in Arms, Hands, or Fingers R / L
- ☐ ☐ Difficulty w/ Excessive (standing, walking, sitting, riding, bending, lifting, twisting or household chores)
- ☐ ☐ Foot Trouble
- ☐ ☐ Spinal Curvature
- ☐ ☐ Joint Pain
- ☐ ☐ Muscle Twitching
- ☐ ☐ Broken Bones
- ☐ ☐ Fractures

EYE/EAR/NOSE/THROAT (Past / Current)

- ☐ ☐ Glasses/Contact Lenses
- ☐ ☐ Pain in Eyes
- ☐ ☐ Light Sensitive
- ☐ ☐ Blurred/Double Vision
- ☐ ☐ Deafness
- ☐ ☐ Ear Ache/Infections
- ☐ ☐ Ear Discharges
- ☐ ☐ Ear Ringing
- ☐ ☐ Frequent Colds/Flu
- ☐ ☐ Hoarseness
- ☐ ☐ Sore Throats
- ☐ ☐ Goiter
- ☐ ☐ Tonsillitis
- ☐ ☐ Nasal Obstruction
- ☐ ☐ Nose Bleeds
- ☐ ☐ Sinusitis
- ☐ ☐ Hay Fever

RESPIRATORY (Past / Current)

- ☐ ☐ Allergy
- ☐ ☐ Asthma/Wheezing
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Chronic Cough
- ☐ ☐ Bronchitis
- ☐ ☐ Spitting Blood
- ☐ ☐ Spitting Phlegm
- ☐ ☐ Chest Pain

GENITO-URINARY

- ☐ ☐ Bed Wetting
- ☐ ☐ Frequent Urination
- ☐ ☐ Inability to Control Urine
- ☐ ☐ Painfull Urination
- ☐ ☐ Blood in Urine
- ☐ ☐ Kidney Infection
- ☐ ☐ Bladder Infection
- ☐ ☐ Prostate Problems
- ☐ ☐ Impotence

WOMEN ONLY (Past / Current)

- ☐ ☐ Menstral Cramps
- ☐ ☐ PMS
- ☐ ☐ Vaginal Discharge
- ☐ ☐ Excessive Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Miscarriage
- ☐ ☐ Painful Periods
- ☐ ☐ Breast Problems
- ☐ ☐ Pregnant

Last Pap ____/____/____

MISCELLANEOUS

- ☐ ☐ Unexplained Weight Loss/Gain
- ☐ ☐ Recent Infections/Night Sweats
- ☐ ☐ Night Pain
- ☐ ☐ Loss of Bowel/Bladder Function
- ☐ ☐ Pain Wakes You From Sleep
- ☐ ☐ Numbing/Tingling in **BOTH** Arms and/or Legs

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ☐ Restless Leg Syndrome
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Liver/Gall Bladder
- ☐ Heart Disease
- ☐ Cancer
- ☐ Thyroid
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ Arthritis Type?__________
- ☐ Epilepsy
- ☐ Mental Illness
- ☐ Eczema
- ☐ HIV Positive
- ☐ Other ____________

(Additional space if needed)

List all Surgeries, Falls, Accidents, and Injuries (even those you thought were no big deal) and dates if known:

____

____

____

Have you ever had X-rays taken? ☐ Yes ☐ No When?__________ By Whom?__________

For what ailments were these X-rays made?__________

Who is your current primary care Doctor?__________

May we contact them regarding your status/progress? ☐ Yes ☐ No

List all Drugs you are taking (include prescription and over the counter medications such as birth control, aspirin, heart pills, laxatives, antacids, cold tablets, etc.)

Type	Purpose	Dosage

ACTIVITIES OF DAILY LIVING (ADL's)

1. Type of mattress (describe)__________ How old?__________
2. Sleeping position? ☐ Side ☐ Stomach ☐ Back
3. Type of pillow? ☐ Foam ☐ Feather ☐ Other __________ How many?__________
4. Average hours of sleep?__________
5. Do you sit on a recliner chair? ☐ Always ☐ Often ☐ Never
6. Do you wear orthotics/heel lifts? ☐ Yes ☐ No If yes, were the impressions taken sitting or standing? __________
7. Do you sit on your wallet? ☐ Yes ☐ No
8. Define your stress level (use1-10 scale, 10 being the most stressful). __________ work __________ home

I hereby attest that the above information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any undisclosed medical information.

Patient's/Guardian's Signature __________ Date __________

(Additional space if needed)

NECK DISABILITY INDEX

Name______________________________ Date____/____/____ File #__________
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are coveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7- Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr.sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs.sleepless.).
- ☐ My sleep is moderately disturbed (2-3 hrs.sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs.sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs.sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

REVISED OSWESTRY DISABILITY

Name ______________________________ Date____/____/____ File #______________
(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not, increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediatley.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain. Manchester University Press 1989: 187-204

Fleuchaus Family Chiropractic
6828-39th Avenue
Kenosha, WI 53142
(262) 652-6000

Informed Consent To Chiropractic Treatment

The nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device to remove nerve irritation or subluxation. You may feel movement in the joint or hear a "click" or a "pop", such as the noise when a knuckle is "cracked". This is the result of gas being released in the joint space. Ancillary procedures such as hot/cold packs, electrical muscle stimulation, therapeutic ultrasound, or traction may be used if the doctor feels it would benefit your case.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscle strain, ligamentous sprain, dislocation of joints, or injury to intervetbral discs, nerves, or the spinal cord. A cerebrovascular injury may result in a stroke upon severe injury to the arteries of the neck. Risks of this complication are extremely rare. It is estimated that this complication is 1:1,000,000 ("The appropriateness of manipulation and mobilization of the cervical spine" Santa Monica, CA:RAND corporation 1996:xiv.(6)

Probability of Risks: Chiropractic procedures are among the safest procedures in human health care services. This is easily demonstrated by malpractice insurance premium rates, where chiropractors have very low malpractice insurance rates when compared to a medical doctor. The risks of complications due to spinal manipulation have been described as RARE. Compared to even a seemingly low risk treatment option such as aspirin, the risk of serious injury is 400 times greater using aspirin than with spinal manipulation.(Terrett, A "Current Concepts in Vertebrobasilar Complications following Spinal Manipulation" page 119) Risks related to the ancillary procedures listed above are also considered RARE.

Other Treatment Options: There are other options available to you for the care of your musculoskeletal condition. These options include medications, hospitalization and surgery. These options have various side effects, many with a much higher probability of risks and complications including death. These options should be discussed and disclosed by your medical doctor prior to undertaking any medical treatment.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes to the involved joints, muscles and ligaments. These changes can further reduce skeletal mobility, and introduce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make rehabilitation more difficult.

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.

____

Printed Name | **Signature** | Date

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization. If you would like to review this policy there is a permanent copy located at the front desk for your review.

Patient Name Printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature

Description of personal representative's authority to act for the patient.

Fleuchaus Family Chiropractic
6828-39th Avenue
Kenosha, WI 53142
(262) 652-6000

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information). If you would like to review this policy there is a permanent copy located at the front desk for your review.

____
Printed Name

____
Authorized Provider Representative

____
Signature

____
Date

____
Date

Fleuchaus Family Chiropractic
6828 39th Avenue
Kenosha, WI 53142

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:________________________ **Last Name:**________________________

Email address: ________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _________________

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (__________)	Offspring: (__________)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: _______________

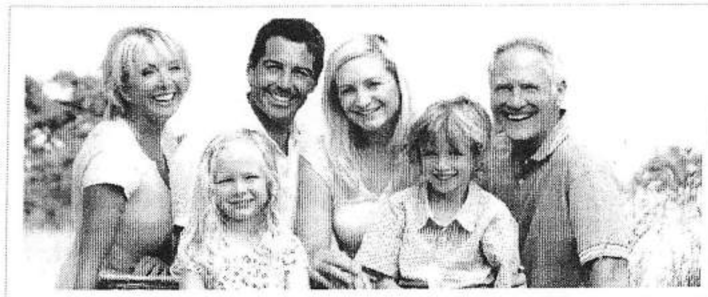
For office use only

Height: ________ Weight:___________ Blood Pressure:_____/_____

Subscriber Enrollment

As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

Get Well and **Stay Well.**



First name : ____________________ Last name : ____________________

Gender : ◯ Male ◯ Female

Date of birth : ______ / ______ / ______ Email address : ____________________

Naturally you can unsubscribe at any time.