DIRKER CHIROPRACTIC, LLC
707 South Taylor Drive
Suite A
Sheboygan, WI 53081

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 feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often than complications from taking a single aspirin tablet.. There has not been a single reported injury in our clinic since its inception in 2003.

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

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks 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 above explanation 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

CONSENT FOR TELEPHONE AND EMAIL APPOINTMENT REMINDERS AND TREATMENT ALTERNATIVES

Your chiropractor and members of the practice staff may need to use your name, address, phone number, email address, and your clinical records to contact you with appointment reminders, and information about treatment alternatives. 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 consenting for us 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.

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

You have the right to refuse to give us your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you choose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give us this consent or revoke it in the future, 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 or information about treatment alternatives at any time.

This consent is effective as of_____. Unless you otherwise revoke it, this consent will expire one year after the date on which you last received treatment or services from us.

I CONSENT to my phone number and/or email address being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

_____	_____
Patient Name Printed	Date
_____	_____
Patient (or Personal Representative) Signature	Authorized Provider Representative
_____	_____
Personal Representative's Name Printed	Personal Representative's Authority

Preferred Telephone Number for This Purpose: _____ ☐ Home ☐ Cell ☐ Work

Preferred Email Address for This Purpose: _____ ☐ Personal ☐ Work

I am acknowledging that I have received a copy of this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my name, address, phone number, email address, and my clinical records to contact me with appointment reminders, and information about treatment alternatives.

_____	_____
Patient Name Printed	Date
_____	_____
Patient (or Personal Representative) Signature	Personal Representative's Authority

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, 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 restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Authorized Provider Representative
Personal Representative's Name Printed	Personal Representative's Authority

I am acknowledging that I have received a copy of the PRIVACY POLICY and this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

Patient Name Printed	Date
Patient (or Personal Representative) Signature	Personal Representative's Authority

DIRKER CHIROPRACTIC, LLC

Dr. Joe A. Dirker
Dr. Jennifer L. Mills
Dr. Matthew J. Stephens
Dr. Elizabeth A. Pfeiffer

707 South Taylor Drive
Suite A
Sheboygan, WI 53081

Telephone: (920) 451-7000
Fax: (920) 451-7100

Welcome!

We look forward to caring for you. Please take some time to fill out this important information.

Today's Date_____/_____/_____

Name: Last_____ First_____ MI_____

Preferred Name: _____ Date of Birth_____/_____/_____

Address:_____ Apt.#_____

City:_____State:_____Zip:_____

Social Security _____-_____-_____ Male □ Female □

Employer:_____ Occupation:_____

Home # (_____)_____ Work # (_____)_____

Cell # (_____)_____ Cell Carrier _____

Preferred Phone #: □ Home □ Cell □ Work Is it okay to call you at work? □ YES □ NO

Email Address_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Partnered

Spouse/Partners Name:_____

Emergency Contact Name:_____ Phone Number: (_____)_____

RESPONSIBLE PARTY if **patient** is under 18:

Name:_____ Telephone: (____)_____

Date of Birth_____/_____/_____ Social Security _____-_____-_____

Relationship to patient:_____

Address:_____ Apt.#_____

City:_____State:_____Zip:_____

Have you ever had chiropractic care before? YES □ NO □

Doctor's Name(s):_____

How did you find out about our office?_____

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Dr. Joe A. Dirker
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Dr. Matthew J. Stephens
Dr. Elizabeth A. Pfeiffer

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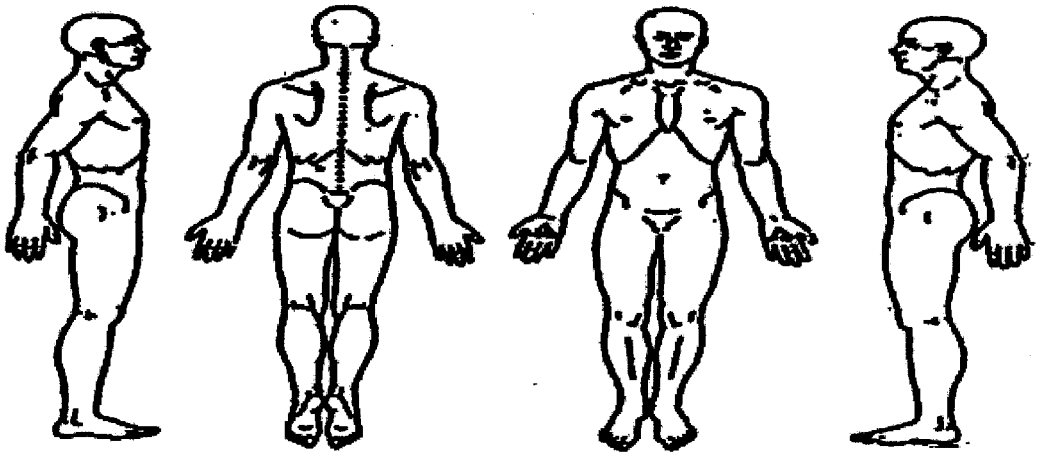
Sheboygan, WI 53081

Telephone: (920) 451-7000
Fax: (920) 451-7100

Name: _____ **Date**: _____

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly
□ Diffuse □ Throbbing □ Achy □ Sore
□ Burning □ Pressure □ Shooting □ Sharp with motion
□ Stiff □ Other:_____

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work/ social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Physical Therapist
□ Massage Therapist □ No One □ Other _____

8. How long have you had this problem? _____

9. How do you think your problem began? _____

10. What aggravates your problem?

□ Sit □ Stand □ Movement □ Sleep □ Work □ Exercise
□ Lifting □ Walking □ Bending □ Driving □ Stress □ Reach/Push/Pull
□ Squatting □ Twisting □ OTHER: _____

OVER→

11. What makes your problem better?

□ Sit □ Stand □ Movement □ Laying down □ Stretching □ Ice
□ Heat □ Walking □ NSAIDS □ Prescriptions □ Exercising □ Resting
□ OTHER: _____

12. What concerns you the most about your problem? _____

_____

13. What does it prevent you from doing? _____

14. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

15. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

16. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

17. 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	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/ Arm Pain	□	□ Osteoporosis/Osteopenia	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ **Abnormal Weight Gain/Loss**	□	□ Dizziness
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Chronic Sinusitis
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Visual Disturbances
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Asthma
□	□ Arthritis	□	□ Hepatitis		**For Females Only**
□	□ **Rheumatoid Arthritis**	□	□ **Liver/Gall Bladder Disorder**	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Other:_____			□	□ Pregnancy

18. List all surgical procedures you've had (i.e. pacemaker, artificial hip, spinal fusion, etc.):

_____

19. Have you ever been hospitalized? □ No □ Yes If yes, when and why _____

20. Have you had other significant past traumas? □ No □ Yes If yes, explain_____

21. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

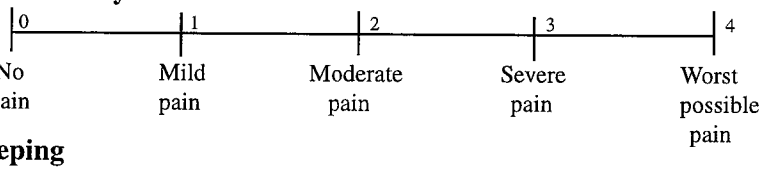
Office Use: **Height:** _____ **Weight:** _____ **BP:** _____

Functional Rating Index

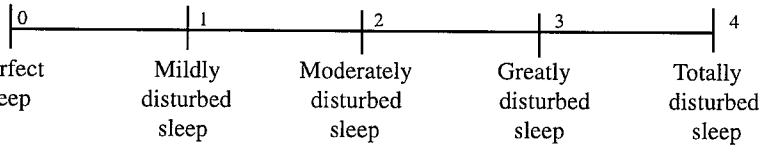
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

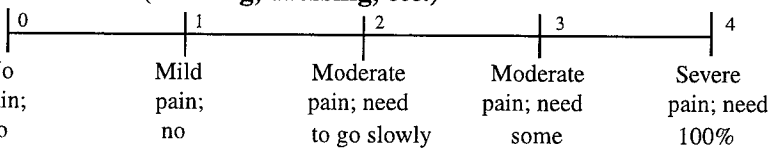
1. Pain Intensity



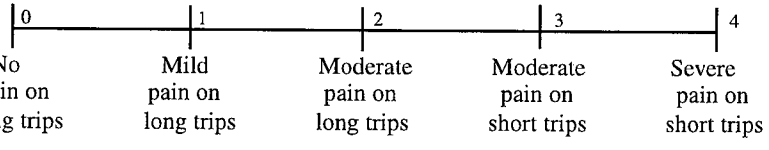
2. Sleeping



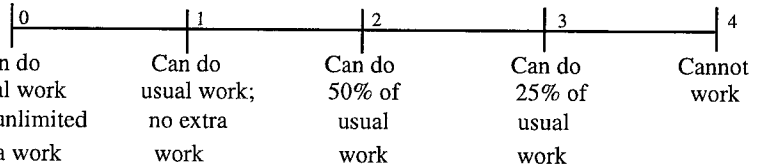
3. Personal Care (washing, dressing, etc.)



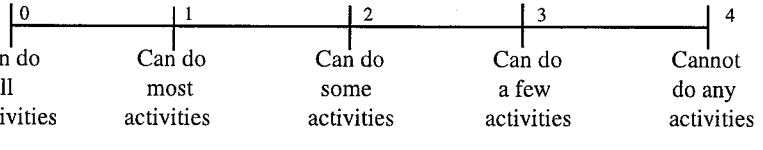
4. Travel (driving, etc.)



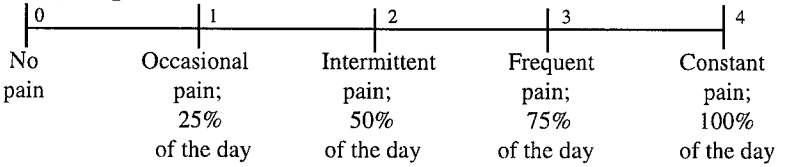
5. Work



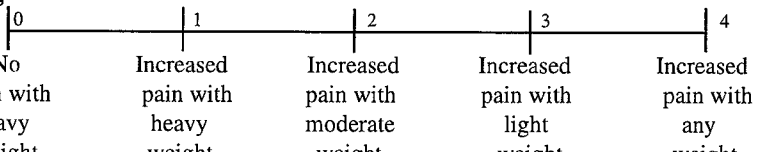
6. Recreation



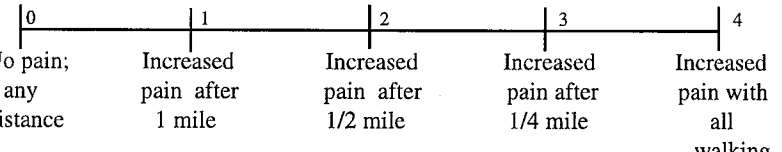
7. Frequency of pain



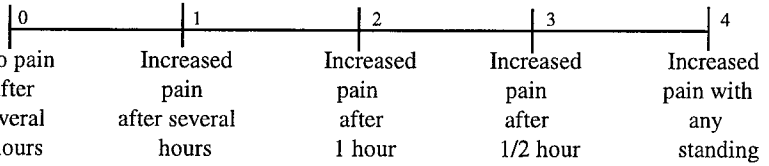
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____