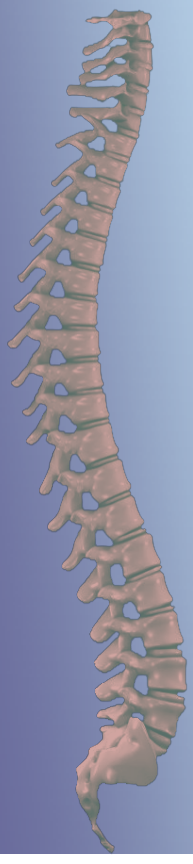
CADENCE CHIROPRACTIC

Welcome to our office!

It is well known that families who maintain strong, healthy, well-aligned spines have greatly improved health. People whose spines are not healthy and kept in proper alignment are much more likely to develop serious health challenges later in life.



ADULT CHIROPRACTIC INTAKE FORM

MY PURPOSE FOR TODAY'S APPOINTMENT IS:

(*check all that apply to you)*

□ I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.

□ I'm here for an evaluation because I'm having health challenges and am looking for a natural health solution.

□ I'm here for an evaluation. I am curious to know if my spine is healthy and to see if I have any problems that I don't know about.

□ I am here for an evaluation because I'm curious to learn more about Chiropractic Care

□ I am here for an evaluation only

□ Other

IF THE DOCTOR FEELS THAT SHE CAN HELP YOU:

(Please check the one that best applies to you)

□ I am willing to follow the doctor's recommendations because I strongly value my health.

□ I am willing to receive care if payment plans are available.

□ I am willing to receive care but only if my insurance pays for all of it.

□ I am not interested in receiving any future care.

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's natural wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's natural ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's natural wisdom. Our only method of achieving this is through specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction.
Signature_____ Date _____

Consent to Treatment of Minor Child

I hereby authorize Cadence Chiropractic to administer treatment as they so deem necessary to my daughter / son / other, (name) _____.

Signature: _____ Date: _____

Witness: _____ Date: _____

Whom may we thank for referring you to this office? _____

NEW PATIENT HEALTH HISTORY

Today's Date: _____ File #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please list your health concerns below:

Health Concern in order of severity	Rate Severity: 1 = mild 10 = unbearable	Have you had the condition before? When?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? _____

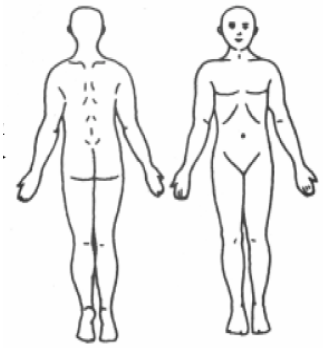
Chiropractor? Y / N Medical Doctor? Y / N Other: _____

Dr's Name? _____

How long ago? _____ What were the results: ☐ Favorable ☐ Unfavorable

→ please explain: _____

_____



PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching
N = Numbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No Explain: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer ___Stroke
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular Issue ___ Other serious conditions: _____

PLEASE identify ALL PAST and **CURRENT** conditions you have:

Headache	Numb/Tingling in arms, hands, fingers	Fainting	Impotence/Sexual Dysfunction	High Blood Pressure
Neck Pain	Numb/Tingling in legs, feet, toes	Double Vision	Digestive Problems	Low Blood Pressure
Jaw Pain/TMJ	Convulsions/Epilepsy	Blurred Vision	Colon Trouble	Asthma
Shoulder Pain	Tremors	Ringing in Ears	Diarrhea/Constipation	Difficulty Breathing
Upper Back Pain	Chest Pain	Hearing Loss	Menopausal Problems	Lung Problems
Mid Back Pain	Pain w/Cough/Sneeze	Depression	PMS	Kidney Trouble
Low Back Pain	Pregnant (Now)	Irritable	Bed Wetting	Gall Bladder Trouble
Hip Pain	Frequent Colds/Flu	Mood Changes	Learning Disability	Liver Trouble
Foot or Knee Problems	Sinus/Drainage Problem	ADD/ADHD	Eating Disorder	Hepatitis (A,B,C)
Elbow or Wrist Problems	Swollen/Painful Joints	Allergies	Ulcers	Other _____
Back Curvature	Dizziness	Prostate Problems	Heartburn	_____
Scoliosis	Loss of Balance	Trouble Sleeping	Heart Problem	_____
Skin Problems				_____

PLEASE List past surgical operations and the date they occurred**:** _____

_____

PLEASE List ALL over the counter and prescription medications you are currently taking**:** _____

_____

When was your last automobile accident?_____

Have you ever been knocked unconscious? When?_____

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: How often do you exercise? _____

I hereby authorize and request payment for services to be made directly to Cadence Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cadence Chiropractic for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____

Doctor's Signature **Date Form Reviewed**

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

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

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctors by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							
Do you use orthotics?							

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Cadence Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

_____ _____

Patient's Signature Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that a more comprehensive version of this "Notice Of Privacy Practice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

_____ _____

Patient's Signature Date

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Release of Information*:*

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This "**Release"** will remain in effect until terminated by me in writing. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

Messages*:*

Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

_____ _____

Patient's Signature Date

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records; we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-ray in our files.

The fee for copying your X-Rays and Video Fluoroscopy study on a disc is $10.00. This fee must be paid in advance.

Digital X-Rays on CD will be available within 72 hours of prepayment and on regular practice hour days.

PLEASE NOTE: X-Rays are utilized in this office to help locate and analyze vertebral subluxations. These X-Rays are not used to investigate for medical pathology. The doctors of Cadence Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you may seek proper medical advise.

By signing below you are agreeing to the above terms and conditions.

Patient Name (Print) Date

Patient's Signature Your Age

FEMALE PATIENTS ONLY:

To the best of my knowledge, I believe I am not pregnant at the time X-Rays are taken at Cadence Chiropractic.

Patient's Signature Date