# WINKELMANN CHIROPRACTIC & INJURY

FOR THE HEALTH IT

**DATE OF APPOINTMENT:** _____

**FULL NAME:** _____

**PREFERRED NAME:**_____ / **DATE OF BIRTH:** _____ / ☐ **MALE** ☐ **FEMALE**

**MAILING ADDRESS:** _____ / **CITY** / **STATE:** _____

**ZIP CODE:** _____ / **PHONE NO.:** _____

**EMAIL** (PLEASE PRINT)**:**_____

**EMPLOYER:** _____ / **POSITION:** _____

**EMERGENCY CONTACT:** _____

**RELATIONSHIP TO YOU:**_____ / **THEIR PHONE NO:** _____

**HOW DID YOU HEAR ABOUT US?** WE GIVE $10 ACCOUNT CREDIT FOR REFERRALS! WRITE DOWN THE NAME OF THE PERSON THAT REFERRED YOU, AND LET US SHOW OUR APPRECIATION!

**NAME OF REFERRAL:** _____

**ARE YOU HERE TO RECEIVE CARE FOR AN AUTO OR WORK-RELATED INJURY? YES ☐ NO ☐**

**DO YOU HAVE ANY APPLICABLE INSURANCE COVERAGE FOR YOUR TREATMENT? YES ☐ NO ☐**

☐ HEALTH INSURANCE
☐ MEDICARE
☐ LIABILITY (AUTO, ETC.)
☐ WORKERS COMPENSATION
☐ AFLAC OR ACCIDENTAL
OTHER _____

**HAVE YOU EVER BEEN TO A CHIROPRACTOR?** YES ☐ NO ☐ / IF SO, HOW LONG AGO? _____

**ARE YOU PREGNANT, OR THINK YOU MIGHT BE?** YES ☐ NO ☐ MAYBE ☐

**DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS? (SELECT ALL THAT APPLY)**

☐ AUTOIMMUNE DISEASE
☐ CANCER
☐ CHEST PAIN
☐ DIABETES
☐ DIZZINESS
☐ DOUBLE VISION
☐ FAINTING
☐ HEADACHES
☐ MUSCLE WEAKNESS
☐ NAUSEA
☐ NUMBNESS / TINGLING
☐ POOR BALANCE
☐ SENSITIVITY TO LIGHT
☐ STROKE
☐ TROUBLE SPEAKING
☐ TROUBLE SWALLOWING

**PLEASE CONTINUE ON NEXT PAGE . 1**

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FOR PROVIDER USE ONLY:

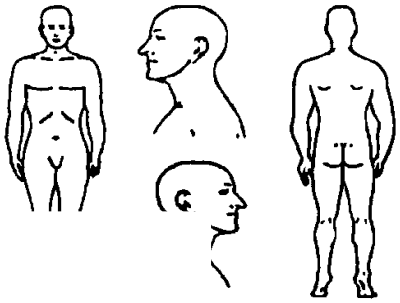
CP:____ M:____ N:____ A:____ X:____ N:____

## SYMPTOM EVALUATION

**WHERE IS YOUR MAIN AREA/REGION OF PAIN/SYMPTOM?**

_____

PLEASE MARK THE AFFECTED AREA ON THE DIAGRAM



**DOES THE PAIN TRAVEL (RADIATE) ANYWHERE?** YES ☐ NO ☐

**IF SO, WHERE?** _____

**DO YOU KNOW WHAT HAS OR COULD HAVE CAUSED YOUR SYMPTOMS?** YES ☐ NO ☐ / IF YES, PLEASE EXPLAIN: _____

_____

**HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT?** _____

**HOW OFTEN IS IT PRESENT THROUGHOUT THE DAY?** ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

**PLEASE RATE YOUR PAIN: RIGHT NOW:**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

**WHEN YOUR PAIN IS THE WORST:**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

**HOW WOULD YOU DESCRIBE YOUR PAIN?** _____
ACHING, BURNING, SHARP, DULL, ETC.

**WHAT MAKES THE SYMPTOMS/PAIN BETTER?** _____

**WHAT MAKES THE SYMPTOMS/PAIN OR WORSE?** _____

**HAVE YOU EXPERIENCED PAIN OR SYMPTOMS SIMILAR TO THIS IN THE PAST?** YES ☐ NO ☐

IF YES, PLEASE EXPLAIN _____

HOW OFTEN DOES THIS PROBLEM REOCCUR? _____

**HAVE YOU HAD ANY PREVIOUS SPINAL SURGERIES?** YES ☐ NO ☐ IF YES, PLEASE EXPLAIN: _____

_____

**PLEASE CONTINUE ON NEXT PAGE . 2**

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FOR PROVIDER USE ONLY:

## REVIEW OF SYSTEMS

**EARS AND EYES:**

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR EARS AND/OR EYES? YES ☐ NO ☐
IF YES, PLEASE EXPLAIN BELOW:

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**NOSE AND THROAT:**

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR NOSE AND/OR THROAT? YES ☐ NO ☐
IF YES, PLEASE EXPLAIN BELOW:

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**LUNGS, HEART, KIDNEYS AND LIVER:**

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR LUNGS, HEART, KIDNEYS AND/OR LIVER?
YES ☐ NO ☐ / IF YES, PLEASE EXPLAIN BELOW:

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**BOWEL SYSTEM, URINATION AND SEXUAL FUNCTION:**

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR BOWEL SYSTEM, URINATION AND/OR SEXUAL FUNCTION? YES ☐ NO ☐ / IF YES, PLEASE EXPLAIN BELOW:

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**ARE YOU EXPERIENCING ANY OTHER SYMPTOMS, NOT PREVIOUSLY ADDRESSED, THAT YOU WOULD LIKE DR. WINKELMANN TO KNOW ABOUT?** YES ☐ NO ☐ / IF YES, PLEASE EXPLAIN BELOW: _____

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## PATIENT SIGNATURE REQUIRED ON LAST PAGE . 3

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# HIPAA NOTICE OF PRIVACY PRACTICES & INFORMED CONSENT:

**HIPAA NOTICE OF PRIVACY PRACTICES**: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW.** IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION (PHI). "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH SERVICES. **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:** YOUR PHI MAY BE USED AND DISCLOSED BY YOUR PHYSICIAN, OUR OFFICE STAFF AND OTHERS OUTSIDE OF OUR OFFICE THAT ARE INVOLVED IN YOUR CARE AND TREATMENT FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO YOU, TO PAY YOUR HEALTH CARE BILLS, TO SUPPORT THE OPERATION OF THE PHYSICIAN'S PRACTICE, AND ANY OTHER USE REQUIRED BY LAW. **TREATMENT:** WE WILL USE AND DISCLOSE YOUR PHI TO PROVIDE, COORDINATE OR MANAGE YOUR HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PHI, AS NECESSARY, TO A HOME HEALTH AGENCY THAT PROVIDES CARE TO YOU OR YOUR PHI MAY BE PROVIDED TO A PHYSICIAN TO WHOM YOU HAVE BEEN REFERRED TO ENSURE THAT THE PHYSICIAN HAS THE NECESSARY INFORMATION TO DIAGNOSE OR TREAT YOU. **PAYMENT:** YOUR PHI WILL BE USED, AS NEEDED, TO OBTAIN PAYMENT FOR YOUR HEALTH CARE SERVICES. FOR EXAMPLE, OBTAINING APPROVAL FOR A HOSPITAL STAY OR OTHER PRE-CERTIFICATIONS OF SERVICES MAY REQUIRE THAT YOUR RELEVANT HEALTH CARE INFORMATION BE DISCLOSED TO A HEALTH PLAN. **HEALTH CARE OPERATIONS:** WE MAY USE OR DISCLOSE, AS NEEDED, YOUR PHI IN ORDER TO SUPPORT THE BUSINESS ACTIVITIES OF YOUR PHYSICIAN'S PRACTICE. THESE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO: QUALITY ASSESSMENT ACTIVITIES, EMPLOYEE REVIEW ACTIVITIES, TRAINING OF MEDICAL STUDENTS, LICENSING, AND CONDUCTING OR ARRANGING FOR OTHER BUSINESS ACTIVITIES. FOR EXAMPLE, WE MAY USE A SIGN-IN-SHEET AT THE REGISTRATION DESK WHERE YOU WILL BE ASKED TO SIGN YOUR NAME AND INDICATE YOUR PHYSICIAN. WE MAY ALSO CALL YOU BY NAME IN THE RECEPTION AREA. WE MAY ALSO DISCLOSE YOUR PHI TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT. **PERMITTED AND REQUIRED USES AND DISCLOSURES:** WE MAY USE OR DISCLOSE YOUR PHI IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION: AS REQUIRED BY LAW, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES, HEALTH OVERSIGHT, ABUSE OR NEGLECT, FOOD AND DRUG ADMINISTRATION REQUIREMENTS, LEGAL PROCEEDINGS, LAW ENFORCEMENT, CORONERS, FUNERAL DIRECTORS, ORGAN DONATION, RESEARCH, CRIMINAL ACTIVITY, MILITARY AND NATIONAL SECURITY ACTIVITIES, WORKER'S COMPENSATION., INMATES. UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE REQUIREMENTS OF SECTION 164.500. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

**YOUR RIGHTS:** YOU HAVE THE RIGHT TO COPY AND INSPECT YOUR PROTECTED HEALTH INFORMATION. UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OR COPY THE FOLLOWING RECORDS: PSYCHOTHERAPY NOTES; INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USE IN, A CIVIL, CRIMINAL OR ADMINISTRATIVE ACTION OR PROCEEDING, AND PHI THAT IS SUBJECT TO LAW THAT PROHIBITS ACCESS TO PHI. **YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION:** THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOUR PHI FOR THE PURPOSE OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PHI NOT BE DISCLOSED TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSES AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY. YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO THE REQUESTED RESTRICTION. IF THE PHYSICIAN BELIEVES THAT IT IS NOT IN YOUR BEST INTEREST, YOUR PHI WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTH CARE PRACTITIONER. **YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION:** YOU ALSO HAVE THE RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE FROM US, UPON REQUEST, EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ALTERNATIVELY I.E. ELECTRONICALLY. **YOU HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION:** IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU HAVE THE RIGHT TO FILE A STATEMENT OF DISAGREEMENT WITH US AND WE MAY PREPARE A REBUTTAL TO YOUR STATEMENT AND WILL PROVIDE YOU WITH A COPY OF ANY SUCH REBUTTAL. YOU ALSO HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PHI. **COMPLAINTS:** YOU MAY COMPLAIN TO US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT. **WE HAVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND WILL INFORM YOU BY MAIL OF ANY CHANGES:** YOU THEN HAVE THE RIGHT TO OBJECT OR WITHDRAW AS PROVIDED IN THIS NOTICE. WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH, THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE FEEL FREE TO CONTACT US IN PERSON OR BY PHONE.

## SIGNATURE REQUIRED ON LAST PAGE . 4

**INFORMED CONSENT:** A CHIROPRACTIC ADJUSTMENT IS A SPECIFIC WAY TO MOVE THE JOINTS OF THE SPINE AND BODY. THIS CAN BE DONE BY HAND OR BY USING AN INSTRUMENT. AS THE JOINTS ARE MOVED, YOU MAY HEAR A "POP" AS PART OF THE PROCESS. THIS IS A NORMAL PHYSIOLOGICAL REACTION.
THERE ARE CERTAIN COMPLICATIONS THAT CAN OCCUR AS A RESULT OF A SPINAL ADJUSTMENT. THESE COMPLICATIONS INCLUDE, BUT ARE NOT LIMITED TO: MUSCLE STRAIN, CERVICAL MYELOPATHY, DISC AND VERTEBRAL INJURY, FRACTURES, STRAINS AND

DISLOCATIONS, BERNARD-HORNER'S SYNDROME (ALSO KNOWN AS OCULOSYMPATHETIC PALSY), COSTOVERTEBRAL STRAINS AND SEPARATION. RARE COMPLICATIONS INCLUDE, BUT ARE NOT LIMITED TO, STROKE. THE MOST COMMON COMPLICATION OR COMPLAINT FOLLOWING A SPINAL ADJUSTMENT IS AN ACHE OR STIFFNESS AT THE SITE OF ADJUSTMENT. I AM AWARE OF THESE COMPLICATIONS AND IN ORDER TO MINIMIZE THEIR OCCURRENCE I WILL TAKE PRECAUTIONS. THESE PRECAUTIONS INCLUDE, BUT ARE NOT LIMITED TO, TAKING A DETAILED CLINICAL HISTORY FROM YOU, AS WELL AS A THOROUGH EXAMINATION. THIS EXAMINATION MAY INCLUDE THE USE OF X-RAYS. THE USE OF X-RAY EQUIPMENT MAY POSE A RISK IF YOU ARE PREGNANT. IF YOU ARE PREGNANT OR SUSPECT THAT YOU MAY BE PREGNANT, PLEASE PROVIDE INFORM THE X-RAY TECHNICIAN.

SPONTANEOUS BLEEDING OR BRUISING/IRREGULAR HEART BEAT/TENDENCY TO BLEED (TAKING ANTICOAGULANT THERAPY)/COMPROMISED IMMUNE SYSTEM/PREVIOUS ADVERSE REACTION TO ACUPUNCTURE OR DRY NEEDLING THERAPY/SEIZURE INDUCED BY PREVIOUS MEDICAL PROCEDURE/UNSTABLE DIABETES/UNSTABLE ANGINA/CONGENITAL OR/ACQUIRED HEART VALVE DISEASE/RECENT CARDIAC SURGERY OR CONGESTIVE CARDIAC FAILURE/RECENT RADIOTHERAPY/VARICOSE VEINS/MALIGNANCY/HEMATOMA/PREGNANCY/ECZEMA OR PSORIASIS/PERIPHERAL NEUROPATHY/RECURRENT INFECTIONS/EPILEPSY/STABLE OR UNSTABLE OR SCHIZOPHRENIA/CHRONIC EDEMA OR LYMPHEDEMA/DEPRESSION/CHRONIC FATIGUE/ACUTE CARDIAC ARRHYTHMIAS/OPEN SKIN WOUNDS OR INJURIES/ALLERGY TO/NICKEL OR CHROMIUM/HUMAN IMMUNODEFICIENCY VIRUS (HIV)/HEPATITIS B OR C

WE STRONGLY ADVISE THAT YOU CONSULT YOUR MEDICAL DOCTOR IF YOU HAVE ANY OF THESE CONDITIONS TO CONFIRM THAT IT IS SAFE FOR YOU TO RECEIVE DRY NEEDLE THERAPY. IF YOU ARE IN ANY DOUBT, PLEASE DO NOT HESITATE TO LET US KNOW.

THE POSSIBLE RISKS AND ADVERSE REACTIONS TO DRY NEEDLING THERAPY INCLUDE BUT ARE NOT LIMITED TO TEMPORARY PAIN, BLEEDING, BRUISING, INFECTION, DIZZINESS, NERVE INJURY, PNEUMOTHORAX, PREGNANCY TERMINATION, CHANGES TO BLOOD PRESSURE, RASH, FAINTING, MUSCLE SORENESS & FATIGUE.

SERIOUS ADVERSE EVENTS (AE'S) PNEUMOTHORAX, CARDIAC TAMPONADE & DAMAGE TO ORGANS (0.04%). MILD OR MODERATE AES INCLUDED BRUISING (7.55%), BLEEDING (4.65%), PAIN DURING TREATMENT (3.01%), AND PAIN AFTER TREATMENT (2.19%). UNCOMMON AES INCLUDE AGGRAVATION OF SYMPTOMS (0.88%), DROWSINESS (0.26%), HEADACHE (0.14%), AND NAUSEA (0.13%). RARE AES FATIGUE (0.04%), ALTERED EMOTIONS (0.04%), SHAKING, ITCHING, CLAUSTROPHOBIA, AND NUMBNESS, ALL 0.01%.--- *BRADY, S ET AL. JOURNAL OF MANUAL AND MANIPULATIVE THERAPY 2013 VOL. 000 NO. 000 (2013)*

MY SIGNATURE BELOW AFFIRMS THE FOLLOWING STATEMENTS.

THERE IS ALWAYS SOME RISK INVOLVED IN ANY PROCEDURE THAT INVOLVES INSERTING NEEDLES OF ANY KIND INTO THE BODY. IT IS POSSIBLE TO PUNCTURE ORGANS (FOR EXAMPLE, LUNGS) OR BLOOD VESSELS. THE MOST SERIOUS RISK, ALTHOUGH IT IS EXTREMELY RARE, IS PNEUMOTHORAX SECONDARY TO LUNG PUNCTURE. I UNDERSTAND HEMATOMAS CAN DEVELOP SECONDARY TO NEEDLE INSERTION. THE POSSIBILITY OF ACCIDENTALLY INSERTING NEEDLE INTO A NERVE ALSO EXISTS. I AM ALSO AWARE THAT VASOVAGAL REACTIONS SOMETIMES OCCUR, RESULTING IN FAINTING. INFECTIONS, THOUGH VERY RARE, HAVE BEEN REPORTED. I UNDERSTAND THAT RELATIVELY BENIGN AND RARELY MORE SERIOUS ADVERSE EVENTS MAY OCCUR.

I ALSO UNDERSTAND THE RISK OF SERIOUS HARM IS HIGHLY UNLIKELY.

PLEASE INFORM US IF YOU HAVE HAD COSMETIC OR SURGICAL IMPLANTS INSERTED INTO YOUR BODY INCLUDING BUT NOT EXCLUSIVE TO BREAST, BUTTOCK OR PECTORAL IMPLANTS.

SIGNATURE BELOW IS ONLY ACKNOWLEDGMENT THAT YOU HAVE RECEIVED OUR HIPAA NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT.

**SIGNATURE** _____
(IF PATIENT IS UNDER 18 YEARS OF AGE, THIS FORM MUST BE SIGNED BY A PARENT OR GUARDIAN)

**PRINT NAME** _____ DATE_____