freedom
CHIROPRACTIC

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

APPLICATION FOR CARE AT FREEDOM CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

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

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

Email Address: _____ Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐Yes ☐ No ☐HSA ☐FSA

Primary Care Physician: _____ Physician Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Phone: _____ Relationship: _____

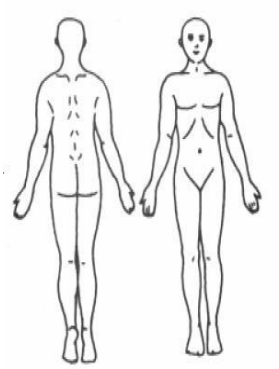
HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Second:_____ Third:_____ Fourth:_____

On a scale of **0 to 10** with **10** being the worse pain and **zero** being no pain, rate your above complaints by numbering each **0 to 10**:
Primary or chief complaint is: _____
Second complaint is: _____
Third complaint is: _____
Fourth complaint: _____
When did the problem(s) begin? _____When is the problem at its worst? ☐ AM ☐ PM ☐mid-day ☐ late PM
How long does it last? ☐ It is constant OR ☐ I experience it on and off the day. OR ☐ It comes and goes throughout the week.
How did the injury happen? _____
Condition(s) every been treated by anyone in the past? ☐ No ☐ Yes If yes, when: _____ By Whom? _____
How long were you under care? _____ What were the results?_____
Name of Previous Chiropractor (if applicable) _____

*PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:



R=Radiating B=Burning D=Dull A=Aching N=Numbness S=Sharp/Stabbing T=Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐Yes ☐No

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

_____

_____

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐Yes If yes how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐No ☐Yes If yes, please state what type of treatment: _____

Who Provided it? _____ How long ago? _____ What were the results? ☐ Favorable ☐ Unfavorable

Please explain: _____

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 every been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

_____Broken Bone _____Dislocations _____Tumors _____Rheumatoid Arthritis _____Fracture _____Disability _____Cancer

_____Heart Attack _____Osteo Arthritis _____Diabetes _____Cerebral Vascular _____Other serious conditions:_____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐grandmother ☐grandfather ☐mother ☐father ☐sister(s) ☐brother(s) ☐ son(s) ☐daughter(s)

Have they ever been treated for their condition? ☐No ☐Yes ☐I do not know

2. Any other hereditary conditions the doctor should be aware of? ☐No ☐Yes_____

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

Please identify **any** conditions (PAST OR CURRENT) you feel may be contributing to your present problem:

	CONDITION/DATE	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DIESEASES			
ADULT DISEASES			

INITIAL NERVE SYSTEM PROFILE

1. Have you been involved in motor vehicle accidents? _____
    a. Dates? _____
    b. Was treatment received? _____
2. When was your most recent strain / stress at work? _____
    a. Please describe the manner of the injury_____
    b. Was treatment received? Please describe _____
    c. Does your job require you remain in long term stressful postures? _____
        (i.e. all day seating, repeated lifting, long term computer use)
3. Spinal traumas in the past? _____
    a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field _____
    b. Trauma as a child? i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____
    c. Work around the house—lifting, bending, woke up with stiff neck, "back went out" _____

INITIAL NUTRITIONAL PROFILE

1. Have you tested with high triglycerides or high cholesterol? ☐Yes ☐No Values? _____
2. Have you tested with high blood pressure? ☐Yes ☐No
3. Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? ☐Yes ☐No
4. How many fast food, refined foods or pre-pared meals do you eat per week? ☐0 ☐1-3 ☐4-6 ☐7+
5. How many servings of fruit do you have on a given day? ☐ 0 ☐ 1 ☐ 2 ☐3 ☐ 4+
6. How man servings of vegetables do you have on a given day? ☐ 0 ☐ 1 ☐ 2 ☐3 ☐ 4-5
7. How many ounces of water do you drink each day? _____

Please list any supplements you take regularly:

_____

_____

_____

INITIAL FITNESS PROFILE

1. How many times per week do you exercise?
2. Cardiovascular _____Hours _____Days/Week
3. Weight Training _____Hours _____Days/Week
4. Low Impact (yoga, etc.) _____Hours _____Days/Week
5. What is your current weight? _____ Is weight loss a goal for you?
6. How willing are you to change any of these things to reach your health goals? (Scale 1-10) _____

INITIAL TOXICITY PROFILE

1. Are you regularly exposed to cleaning products or industrial chemicals? ☐ Yes ☐ No
2. Have you ever noticed mold growing in your home or your place of work?☐ Yes ☐ No
3. Does your home, work, school, or car have damp or mildew smell? ☐ Yes ☐ No
4. Have you received a full standard profile of vaccinations? ☐ Yes ☐ No
5. Do you receive yearly flu shots? ☐Yes ☐ No How many flu shots have you received? _____ (estimate)
6. Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?☐Yes ☐ No
7. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ☐ Yes ☐ No

INITIAL STRESS PROFILE

1. How many hours of sleep do you average each night? _____
2. Do you ever take medication to go to sleep or relax? ☐ Yes ☐ No
3. Do you experience feelings of anxiety or depression? ☐ Yes ☐ No
4. Do you feel like you do not give enough time or attention to important areas in your life like family, personal growth, or a hobby? ☐ Yes ☐ No
5. Do you experience feelings of anxiety about completing tasks? ☐ Yes ☐ No

List Prescription & Non-Prescription drugs you take:

_____

_____

_____

Please mark **P** for in the **Past**, **C** for **Currently** have and **N** for **Never**

___Headache	___Pregnant (now)	___Dizziness	___Prostate Problems	___Ulcers	___Loss of Balance	___Frequent Colds/Flu
___Neck Pain	___Impotence/Sexual Dysfunction	___Heartburn	___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems
___Upper Back Pain	___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure	___Heart Problem
___Mid Back Pain	___Chest Pain	___Blurred Vision	____Diarrhea/Constipation	___Low Blood Pressure	___Ringing in ears	___Pain with cough or sneeze
___Lower Back Problems	___Menopausal Problems	___Difficulty Breathing	___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS
___Scoliosis	___Back Curvature	___Swollen or Painful Joints	___Irritable	___Bedwetting	___Kidney Trouble	___Lung Problems
___Numbing or Tingling arms, hands, fingers	___Mood Changes	___Learning Disability	___Gall Bladder Trouble	___Skin Problems	___ADD or ADHD	___Eating Disorder
___Numbing or Tingling legs, feet, toes	___Allergies	___Trouble Sleeping	___Hepatitis (A, B, C)			

ACTIVITIES OF DAILY LIVING/SYMPTOMS/MEDICATIONS

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 1)

WELCOME. We are honored to be part of your journey to better health. Please read these policies and consent carefully. We feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. If you have questions or anything is unclear, please let a member of our staff know before submitting your ***Application for Care***. It is in everyone's best interest that your decision as to whether you wish to become a patient is informed. Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

FIRST THINGS FIRST: Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

CHIROPRACTIC CARE*:* When a patient seeks chiropractic care, it is essential that the patient and doctor are working toward the same objective. Chiropractic is a branch of the healing arts distinct from other branches (e.g. osteopathic or allopathic). Doctors of chiropractic view health as a continuum from optimal health, to hidden imbalances, to disease. Rather than treating disease, chiropractic aims to improve health by eliminating underlying imbalances that interfere with the body's functioning. Such imbalances include subluxation, a major interference to the expression of the body's innate wisdom. Our doctors use specific spinal correction and musculoskeletal techniques to help eliminate subluxation. We also use diagnostic testing and nutritional remedial measures to help achieve homeostasis - a dynamic equilibrium, in which the body continuously changes to maintain optimal internal stability in response to external conditions. As doctors of chiropractic, we do not prescribe drugs or perform surgery and all changes to prescription medications must be made by your prescribing provider. We may, however, recommend homeopathic and botanical medicines, vitamins, minerals, phytonutrients, antioxidants, enzymes, glandular extracts, non-prescription drugs, and medical goods and devices. Although we may screen for the prevention and early detection of cancer, doctors of chiropractic do not treat cancer. We may, however, work with patients who have cancer in conjunction with, but not replacing, drugs, surgery, or chemotherapy. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

RISKS: Chiropractic adjustment involves some risk including, without limit, fractures, disc injury, sprains, dislocation, and vascular injuries/stroke. Hidden conditions, such as tumors and vascular disorders, may increase this risk. Although the nutritional remedial measures we recommend are generally considered safe, they involve some risk including, without limit, changes in blood sugar, allergic reaction, and gastrointestinal upset. They may also be inappropriate during pregnancy, toxic in large doses, and may interact with certain drugs. You agree to consult with your prescribing physician/provider about any prescription drugs you are taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. You also agree to immediately report suspected pregnancy or any potential interactions to us and your prescribing providers.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 2)

ALTERNATIVES: I understand that the alternatives include doing nothing and/or relying solely on care from providers in other branches of the healing arts. We always encourage you to communicate with your other health providers about your care.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for products purchased or services rendered.

I hereby authorize payment to be made directly to Freedom 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 Freedom Chiropractic for any and all services I receive at this office.

PATIENT PRIVACY: The majority of care takes place in an open bay area. Accordingly, conversations you have with the doctor may be overheard by others. To maintain privacy, if you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

REPORT OF FINDINGS: To enhance understanding of our approach, you will be scheduled for a "Report of Findings" following your first appointment. Attendance is required for individuals who wish to become patients of this practice. Because the results of your examinations and care recommendations will be discussed at that time, we strongly urge you to invite your spouse or a significant other to attend. We know that when a patient's family understands the goals of care and how restoring and maintaining health can affect their lives as well, they become supportive in making important treatment decisions.

QUESTIONS AND ANSWERS: I have read and fully understand this consent and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. Knowing the risks of chiropractic care, I consent to chiropractic care and recommendations.

EMAILS: I understand that by providing my email address, I authorize Freedom Chiropractic to send me emails.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!

Note: Patient retains the above Notice of Office Policies and Freedom Chiropractic retains the signature sheet.

FREEDOM CHIROPRACTIC POLICIES & CONSENT TO CARE (PAGE 3)

Patient initials:* _____*-retaining pages 1 & 2 of 3

I hereby acknowledge receiving a copy of the practices 'Freedom Chiropractic Policies & Consent to Care' a three page document, the first two pages of which I have read and retained. This third page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name (Print) DOB

_____ _____

Patient Signature Date

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (PAGE 1)

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner, and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail Privacy Notice".
3. To request mailings to an address different that residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Jason Cahill, D.C. at (719) 533-0303.
If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

FREEDOM CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (PAGE 2)

Patient initials: _____-retaining page 1 of 2

Freedom Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Freedom Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. 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.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name (Print) DOB

_____ _____

Patient Signature Date

HIPAA CONSENT FORM

Freedom Chiropractic is committed to insuring the privacy and confidentiality for your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

To whom may we speak with other than yourself regarding your medical care?
(If more than one, please list all)

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other

Name: _____ Phone: _____

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other

Name: _____ Phone: _____

☐ Spouse ☐ Child ☐ Sibling ☐ Care Giver ☐ Friend ☐ Other

Name: _____ Phone: _____

May we leave a voicemail on your primary phone number? ☐ Yes ☐ No

May we leave a voicemail on your work phone number? ☐ Yes ☐ No

May we leave a voicemail on your alternate phone number? ☐ Yes ☐ No

May we mail medical information to your home? ☐ Yes ☐ No

I have been made aware of the privacy policies of Freedom Chiropractic, and have received (or made available to me) a copy of the Notice of Privacy Practices of Freedom Chiropractic.

_____ _____

Patient Signature **Date**