Alpine Family Chiropractic Center

Patient Name:_____ DOB:_____ Age:_____ Sex: M / F **Marital Status:** M S D W
Address:_____ City_____ State _____ Zip Code_____
Cell Phone:_____ May we leave a message? Yes / NO **Email:** _____
Occupation:_____ Employer:_____ **Phone:_____**
Who may we thank for referring you to our office?_____ □ **Google** □ **Website**
Emergency Contact:_____ Phone Number:_____

Past Health History:

Surgeries:

Date:	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Previous Injury or Trauma: □ NONE _____
Have you ever broken any bones? □ NONE **Which?_____**
Allergies: □ NONE _____

Family Health History:

Do you have a family history of? (**Please indicate all that apply**)
□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family:

Cause of parents' or siblings' death	Age at death
_____	
_____	
_____	
_____	

Social and Occupational History:
Job description: _____
Work schedule: _____
Recreational activities: _____
Lifestyle: Hobbies: □ NONE_____ **Level of Exercise:** □ NONE_____
Alcohol Use: □ NONE_____ **Drug Use:** □ NONE_____
Tobacco Use: □ NONE □ Smoke □ Chew How much?_____ **Diet:**_____

Medications:	Reason for taking
_____	
_____	
_____	
_____	
_____	
_____	
_____	

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Alpine Family Chiropractic Center** for services performed.

Patient or Guardian Signature _____ Date_____ Dr. Reviewed
Your signature to these documents indicates that the above information is True and Correct**.**

Informed Consent to Care

Alpine Family Chiropractic believes that you are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with care, alternatives, and potential effects on your health if you choose not to receive care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable. We may also make referrals for advanced imaging and/or other providers like Physiatry, Physical Therapy, Acupuncture and Massage Therapy.

Chiropractic care involves what is known as a **chiropractic adjustment**. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or instruments to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are **not guaranteed**. As with all health care interventions, there are some risks to care including, but not limited to: **muscle spasms**, **aggravation and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies such as heat and ice packs, fractures, disc injuries, strokes, sprains, strains, and dislocations.** In particular you should note:

1) Some patients may experience some stiffness or soreness following the first few days of treatment.

2) Some types of Neck manipulation have been associated with stroke; strokes from chiropractic adjustments are very rare. With respect to **STROKES,** there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic treatment can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in **one in one million to one in two million cervical adjustments.**

3) Alpine Family Chiropractic will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have acknowledged that I have had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care and manual therapy as it is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from Alpine Family Chiropractic for my present condition and for any future condition(s) for which I seek chiropractic care or manual care.

Patient Name:_____ Signature:_____ Date:_____

Parent/Guardian:_____ Signature:_____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information 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 protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information 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 protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information 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, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, 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 waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures 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 an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name

Symptom 1 _____

On a scale from **0-10**, with **10** being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What **PERCENTAGE %** of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin **SUDDENLY** or **GRADUALLY**? (circle one)
When did the symptom begin? _____ How did the symptom begin? _____

What makes the symptom **WORSE**? (circle all that apply): nothing, any movement, bending of the neck in all directions, bending forward/backward at waist, tilting R/L at waist, twisting R/L at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, changing positions, lying down, working, exercising, laying on R/L side in bed

What makes the symptom **BETTER**? (circle all that apply): nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other_____

Describe the **QUALITY** of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff , Other _____

Does the symptom **RADIATE** to another part of your body (circle one): YES NO If yes, where? _____

Is the symptom **WORSE** at certain times of the day or night? No difference Morning Afternoon Night

Have you received treatment for this condition? (circle all that apply) None/ Anti-inflammatory meds / Pain medication, Muscle relaxers / Trigger point injections / Cortisone injections, Surgery, Massage / Physical Therapy / Chiropractic

Symptom 2 _____

On a scale from **0-10**, with **10** being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What **PERCENTAGE %** of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin **SUDDENLY** or **GRADUALLY**? (circle one)
When did the symptom begin? _____ How did the symptom begin? _____

What makes the symptom **WORSE**? (circle all that apply): nothing, any movement, bending of the neck in all directions, bending forward/backward at waist, tilting R/L at waist, twisting R/L at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, changing positions, lying down, working, exercising, laying on R/L side in bed

What makes the symptom **BETTER**? (circle all that apply): nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other_____

Describe the **QUALITY** of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff , Other _____

Does the symptom **RADIATE** to another part of your body (circle one): YES NO If yes, where? _____

Is the symptom **WORSE** at certain times of the day or night? No difference Morning Afternoon Night

Have you received treatment for this condition? (circle all that apply) None/ Anti-inflammatory meds/ Pain medication/ Muscle relaxers / Trigger point injections / Cortisone injections/ Surgery/ Massage / Physical Therapy / Chiropractic

Symptom 3 _____

On a scale from **0-10**, with **10** being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What **PERCENTAGE %** of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin **SUDDENLY** or **GRADUALLY**? (circle one)
When did the symptom begin? _____ How did the symptom begin? _____

What makes the symptom **WORSE**? (circle all that apply): nothing, any movement, bending of the neck in all directions, bending forward/backward at waist, tilting R/L at waist, twisting R/L at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, changing positions, lying down, working, exercising, laying on R/L side in bed

What makes the symptom **BETTER**? (circle all that apply): nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other_____

Describe the **QUALITY** of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff , Other _____

Does the symptom **RADIATE** to another part of your body (circle one): YES / NO If yes, where? _____

Is the symptom **WORSE** at certain times of the day or night? No difference Morning Afternoon Night

Have you received treatment for this condition? None, Anti-inflammatory meds / Pain medication, Muscle relaxers / Trigger point injections / Cortisone injections, Surgery, Massage / Physical Therapy / Chiropractic

Symptom 4 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

What PERCENTAGE % of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin SUDDENLY or GRADUALLY? (circle one)
When did the symptom begin? _____ How did the symptom begin? _____

What makes the symptom **WORSE**? (circle all that apply): nothing, any movement, bending of the neck in all directions, bending forward/backward at waist, tilting R/L at waist, twisting R/L at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, changing positions, lying down, working, exercising, laying on R/L side in bed

What makes the symptom **BETTER**? (circle all that apply): nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other_____

Describe the **QUALITY** of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff , Other _____

Does the symptom **RADIATE** to another part of your body (circle one): YES / NO If yes, where? _____

Is the symptom **WORSE** at certain times of the day or night? No difference Morning Afternoon Night

Have you received treatment for this condition? (circle all that apply) None, Anti-inflammatory meds, Pain medication, Muscle relaxers, Trigger point injections, Cortisone injections, Surgery, Massage, Physical Therapy, Chiropractic