TWISTED ROOTS CHIROPRACTIC

110 N. Mountain Blvd.
Mountain Top PA 18707
570 261 7792

All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

Please Fill Out Form Completely

(Please Print) Todays Date: _____

Patient Name: _____ Birth-date: _____

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

Home/Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Primary Care Physician: _____

***How did you hear about our office*??? _____**

Have consulted a Chiropractic before? O No O Yes When? _____ If so, Whom _____

List other doctors consulted for these conditions:
(1) _____ Date seen _____

(2) _____ Date seen _____

Is this injury work-related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____ (if yes, complete below)

Your Auto Ins. Co. _____ Policy # _____ Claim # _____

Please Mark any Complaints or Regions of Pain (Mark all that apply)

O Neck Pain O Mid-Back Pain O Low Back Pain O Sacral/Buttock Pain

O Right Hip O Left Hip O Right Shoulder O Left Shoulder

O Right Knee O Left Knee O Right Elbow O Left Elbow

O Right Ankle-Foot O Left Ankle-Foot O Right Wrist-Hand O Left Wrist-Hand

O Headaches O Sinus Issues O Muscle Cramps O Muscle Fatigue O Numbness

Are your symptoms: □ **Getting worse** □ **Getting better** □ **Staying the same**

What is your chief complaint? _____
When did it start? _____
What caused it? _____
What makes pain worse? _____
What makes pain better? _____
Does the pain go down arms or legs? If yes describe _____
Do you have numbness in your hands or feet? If yes describe _____

Doctors Initials _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

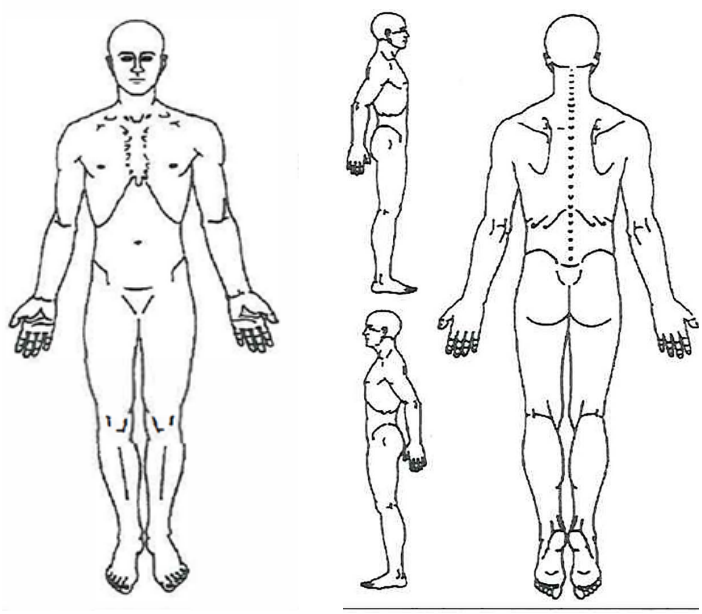
Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

When do you feel it most? ☐AM ☐ PM Explain: _____

Please show where on the body below you are experiencing all of your current complaints by circling the area and placing the letter(s) on the left of that specific area.

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Walking	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

Pain Relievers O Daily O Weekly How Much?_____
Alcohol Use O Daily O Weekly How Much?_____
Tobacco Use O Daily O Weekly How Much?_____
Coffee Use O Daily O Weekly How Much?_____
Exercising O Daily O Weekly How Much? _____

Are you pregnant? ☐ Yes ☐ No **Number of pregnancies?** **Number of miscarriages?**

Have you ever had Surgery (Please include all Surgeries)

*(1)Type*_____ *When*_____

*(2)Type*_____ *When*_____

*(3)Type*_____ *When*_____

Accidents or Injuries in the past (please list all)

Doctors Initials _____

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild	Moderate	Severe
Sitting	○	○	○	○
Rising out of a chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying Down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a Car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild	Moderate	Severe
Grocery Shopping	○	○	○	○
Household Chores	○	○	○	○
Yardwork	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence designed to reduce or correct vertebral subluxation. Chiropractic care is a sperate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my professional health information is protected and released on my behalf for seeking reimbursement for any involved third parties.

Initials _____ I realize that electric stimulation therapy my be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health.

I authorize Twisted Roots Chiropractic to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature: _____ Date: _____

Doctors Initials _____

Patient Treatment Policy

Thank you for choosing Twisted Roots Chiropractic for your health care needs. Please review our office policy to help us ensure that we are providing you with the best in quality, attention and care.

Please address any concerns with the Doctor.

Patient Name: _____ Date: _____

Please attend each of your scheduled visits and arrive on time, so that we can provide you the best care in a timely manner.

- Please provide a 24-hour notice if you are unable to attend your visit so we may offer the appointment time to another patient.
- If you miss an appointment, we ask that you please schedule within the current week so we can keep you on track for your health plan goals.
- If you cancel multiple appointments, your future appointments will be removed from the schedule and you will be asked to reschedule them.
- If you do not show or cancel within 24 hours for 2 consecutive appointments, your future appointments will be removed from the schedule. If you wish to continue you will have to be approved by the Doctor to schedule an appointment.

We Thank You for choosing Twisted Roots Chiropractic and we ask for your assistance in following this policy.

Patient Signature: _____

Twisted Roots Chiropractic

Informed Consent for Care

Patient Name:_____ Date:_____

FOR EVERYONE

You have the right, as a patient, to be informed about the condition of your health and the recommended care so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives. When a patient seeks chiropractic health care and we accept a patient for such care, it is important for all of us to be working toward the same objective and to be clear about what the objective is and what method will be used to attain it.

I _____, do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues, physical therapy and rehabilitative exercise.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems. I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruises • Dizziness/Light Headed • Fractures/Joint Injury
Stroke/Vertebral Artery Tear • Physical Therapy Burns

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read or have had read to me the above explanation of chiropractic treatment.

I have read and understand the above statements and accept chiropractic care at TWISTED ROOTS CHIROPRACTIC.

X_____ _____
Patient Signature (or parent/guardian) Date

Notice of Privacy Policy Acknowledgement
Patient Acknowledgement to review and receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

X _____ _____
Patient Signature (or parent/guardian) Date

FOR PARENTS ONLY

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____
Parent/guardian signature Date