INTEGRITY FAMILY CHIROPRACTIC

Patient Information

Patient's Full Name: _____ Date :_____

Home #:_____ Cell #:_____ Email:_____

Date of Birth:____/____/____ Social Security #:_____-____-_____

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

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced # of Children/Ages_____

Occupation:_____ Hours/Week_____ Work #:_____

Spouse's Name:_____ Phone #:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Payment Method: ☐ Cash ☐ Check ☐ MasterCard/Visa/HSA/FSA ☐ UHC/UMR ☐ Medicare/Humana

Whom may we thank for referring you to us?_____

Or how did you hear about us?_____

*We all experience physical, chemical, and emotional stresses that occur daily and can accumulate over time and result in the loss of health. Most times the effects of our choices are silent and gradual over years, not felt until they become serious or too late to correct. As a holistic & wellness chiropractic office, our main focus is on your ability to be **healthy**, not the treatment of a particular disease. We care about you and your short and long-term goals. Our goals are to offer you the opportunity of improving your current and future health.*

Reason for Consulting Integrity Family Chiropractic:

Primary reason you are seeking our help today:_____

_____

_____

Have you had this problem longer than a week or two? ☐ Yes ☐ No If yes, how long?_____

Have you ever been to a Certified Wellness Healthcare Provider before? ☐ Yes ☐ No

If yes, who?_____ How long ago?_____

Have you ever been to a chiropractor before? ☐ Yes ☐ No

If yes, who?_____ How long ago?_____

Why did you seek help in the past?_____

Please circle any of the following that are part of your health picture (past or present):

AIDS/HIV	Cancer	Digestive Problems	Headaches	Psychiatric Care
Allergies	Type:	Fibromyalgia	#/month:	Sleep Problems
Anorexia/Bulimia	Celiac Disease	Gout	Infertility	Stroke
Anxiety	Chronic Fatigue	Herniated Disc	Kidney Disease	Thyroid Problems
Asthma	Crohn's/U.C.	High Cholesterol	Liver Disease	Any Others?
AutoImmune Disese	Depression	Heart Disease	Menstrual Problems	
Type:	Diabetes	Heart Burn	Osteoporosis	

Body Chart:

We are going to evaluate your posture and the health of your entire spine today, but if you have any painful or specific areas you would like us to address please list the region(s) under symptom #1-#3 and indicate the areas of discomfort on the body chart using the criteria below (**X,/,#**):

Symptom #1:_____

Rate Discomfort (1-10):_____

Symptom #2:_____

Rate Discomfort (1-10):_____

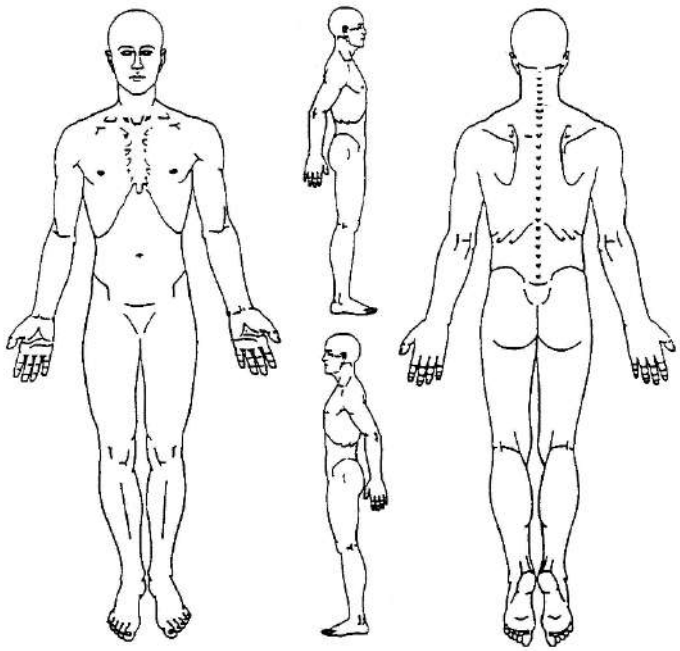
Symptom #3:_____

Rate Discomfort (1-10):_____

Pain/Discomfort **(XXX)**

Numbness (**///**)

Tingling (**###**)



Please answer the following questions to help explain your symptoms:

Have you detected any possible relationship of your current symptoms with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain:_____ Results:_____

Are you currently pregnant? ☐ Yes ☐ No

What type of care are you interested in:

☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

What is your long-term goal from care (e.g. return to hobby/activity without discomfort, play with kids or grandkids, prevent future flares/injury, ease of labor/delivery, etc)?_____

Please list any other concerns or health goals you want to share?

_____

_____

Past Surgeries, Significant Traumas, or Broken Bones (& approximate date):

Please list current supplements you take:	**Please list current medications (Rx & OTC):**
1.	1.
2.	2,
3.	3.
4.	4.

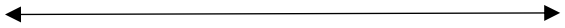
Lifestyle Health Risk Assessment:

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

How are you basing your answer (check all that apply)? ☐ BMI/body weight ☐ How you feel ☐ Basic lab work ☐ Diagnosed Illnesses ☐ Loss of function ☐ # medications used ☐ Your ability to manage stress ☐ Your Anti-inflammatory Diet ☐ 10,000+ Steps/day

At what point on the graph do you think symptoms typically develop (circle % of function):

0% 10 20 30 40 50 60 70 80 90 100% (**Normal Function**)



Movement Habits & Exercise:

I average sitting (circle # hours per day): 1 2 3 4 5 6 7 8 9 10
(only count the hour if you have not gotten up for a movement break)

I exercise or workout 30+ minutes (circle # days per week): 0 1 2 3 4 5 6 7

What do you do for exercise?:_____

I do ongoing posture or spinal corrective exercises (circle # days per week): 0 1 2 3 4 5 6 7

I get checked/adjusted by a qualified chiropractor at least every 90 days: ☐ Yes ☐ No

Mindset, Stress Levels, & Spiritual Beliefs:

My long-term health outcome and quality of life is mostly determined by:

☐ Family History/Genetics ☐ My lifestyle choices ☐ Not Sure

I believe (circle all that apply): "I am responsible for my current & future state of health"
"I am set in my ways" "I can grow and improve" "My health & where I'm at is not within my control"

How many days a week do you perceive as being *very* stressful: 0 1 2 3 4 5 6 7

What do you do to manage stress: _____

My spiritual or religious beliefs can be summed up as:

☐ I prefer not to say

☐ I don't believe in God or a god

☐ I believe in a higher power

☐ I am a (indicate religion): _____

Nutrition & Inflammatory Levels:

How is your dietary intake (Circle/Rate it 1-10): 1 2 3 4 5 6 7 8 9 10 Not Sure

Describe it (circle all that apply): Anti-inflammatory Pro-inflammatory Mostly Whole Foods
Mostly Processed Foods Sufficient in required nutrients Not Sure Other:_____

Quality Fish Oil	Yes No	If yes, how many milligrams per day?_____
Probiotics	Yes No	If yes, containing L Plantarum? Yes No
Whole Food Multivitamin	Yes No	If yes, what is it?_____

Informed Consent

Medical doctors, chiropractors, osteopaths, and physical therapists who perform manipulation or any procedure are required by law to obtain your informed consent before starting care.

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 manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy/rehabilitative exercises may also be used.

Although spinal and extremity manipulations/adjustments are 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: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Headache &/or Dizziness: Temporary symptoms like a mild headache, dizziness and/or nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage associated with stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

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

Alternative Treatment 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.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of some value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglective care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic care. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian Date: _____

(if a minor)

_____ Signature of Witness or Doctor Date: _____

Dry Needling Informed Consent

Please review the following information PRIOR to consenting to application of dry needling techniques which may be recommended by our office as part of your plan of care. Dry Needling is not acupuncture. However, it is a technique that utilizes thin, solid filament needles. This needling technique is used specifically to treat myofascial trigger points, muscle spasms, or dysfunctional tissue. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure:

- **Pain**. When a needle is inserted in the correct location, it may briefly reproduce a muscular ache or a twitching response which indicates the technique should be effective in reducing the symptom. You may experience a muscular ache for one or two days followed by an expected improvement in your overall symptoms. It is extremely important that your doctor is made aware if you are feeling uncomfortable with the treatment.

- **Infection**. Any form of skin penetration creates an opportunity for bacteria to enter the system. In order to minimize the risk, your doctor will follow the proper disinfection procedures and will use only the sterile disposable single-use needles.

- **Bruising or Bleeding**. On occasion you may experience a small painless bruise or blood spotting in the treated region. Bruising and the blood spotting of this nature would clear very quickly.

- **Drowsiness, fatigue and autonomic responses**. On occasion you may experience a feeling of tiredness, nausea, dizziness, sweating; if this occurs, you will be asked to avoid driving until the feeling has passes; Change in blood pressure, heart rate, flushing of the face or breathing rate are involuntary reflexes which may change temporarily as a result of dry needling; these occur rarely and should give no cause for concern.

- **Pneumothorax**. There have been approximately 100 reported cases worldwide of acupuncture needles puncturing a lung. This only occurs when needles are inserted too deeply or incorrectly. Pneumothorax is a serious medical condition requiring admission to hospital. Your Doctor has been trained to avoid the lungs and limit needle depth to avoid this occurring.

Please Circle/Indicate below if you <u>currently</u> have any of the following conditions:

HIV or AIDS	Diabetes	Pacemaker
Hepatitis	Cancer	Unstable Blood Pressure
Current or Recent Infection	Blood Thinning Medication	Immunosuppressant Medication

I have read this form and I understand the risks involved with dry needling therapy. I have had the opportunity to ask questions and express any concerns, of which have been answered to my satisfaction. I also agree to advise my Chiropractor of any and all changes in my physical condition whether or not I believe these changes will affect my treatment or plan of care. I consent to dry needling treatment provided by my Chiropractor. Patient Signature:

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian Date: _____

(if a minor)

Insurance Authorization and Assignment Statement (if applicable)

Please inform us if you do not agree with any of the below information before signing.

• I authorize the release of all medical information necessary to process any claims pertinent to my medical care.

• I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian Date: _____

(if a minor)

24 Hour Cancellation Policy

Please inform us if you do not agree with any of the below information before signing.

We require 24 hours notice in the event of a cancellation. **There is a $35 charge for a cancellation or no-show without proper notice**. This charge will not be covered by your insurance, but will be assessed to your account and have to be paid with your card on file or by you personally at your next appointment.

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian Date: _____

(if a minor)

Patient Financial Responsibility Statement

Please inform us if you do not agree with any of the below information before signing.

• I understand that all accounts (including insurance, Medicare, personal injury and worker's compensation) are the full responsibility of the patient/patient guarantor.

• I understand that all deductibles, copay's, co-insurance and non-covered services are my responsibility.

• In the case of default of payment, I promise to pay any legal interest on the balance due, collection costs (35% of balance due) and reasonable attorney fees incurred to satisfy this account.

• Integrity Family Chiropractic, LLC. will keep you informed of any outstanding balance via statements. Any balance not paid by the due date will be subject to the following collections policy. Any balance not paid by 90 days will be forwarded to our collections agency. We will gladly accept reasonable payments on your account, but you must contact us for an agreed upon payment plan and you will be responsible for making all payments in a timely fashion.

• I understand all statements past due over 60 days will receive a late fee in the amount of $5.00/day for each day over due.

• I understand all returned checks will be charged a $20 NSF (non-sufficient funds) fee.

_____ Signature of Patient Date: _____

_____ Signature of Parent or Guardian Date: _____

(if a minor)

INTEGRITY FAMILY CHIROPRACTIC

3 Steps to Health

If now is your appointment time lets get started and you can return to this later :)
(This form is optional, but a helpful exercise)

What 3 behaviors/activities that if you chose to ADD would create a benefit to your current and future health?

1._____

2._____

3._____

What do you feel is a limiting factor(s) to accomplishing these 3 changes in the next 12 months?

_____

_____

_____

What 3 behaviors/activities that if you chose to ELIMINATE would create a benefit to your current and future health?

1._____

2._____

3._____

What do you feel is a limiting factor(s) in accomplishing this is the next 12 months?

_____

_____

_____

What is your WHY? (My Purpose for getting well...)

_____

_____

_____

_____