PATIENT INFORMATION

THE CHIROPRACTIC PLACE

*First Name*_____ *Last Name*_____

Gender ☐ *M* ☐ *F* *Date of Birth*_____ /_____ /_____ *Age*_____

*Home Address*_____

*City*_____ *State*_____ *Zip Code*_____

*Phone*_____ ☐ *W* ☐ *H* ☐ *C* *2nd Phone*_____ ☐ *W* ☐ *H* ☐ *C*

*Email*_____

What is your preferred method of communication? ☐ *Phone* ☐ *Text* ☐ *Email*

*Employer*_____

*Work Address*_____

*City*_____ *State*_____ *Zip Code*_____

*Emergency Contact*_____ *Phone*_____ ☐ *W* ☐ *H* ☐ *C*

Date of last medical check-up: _____ *Reason:* _____

Are you Medicare Eligible? ☐ *Yes* ☐ *No*

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ *Yes* ☐ *No*

Are you looking to/for: ☐ *Temporary Relief* ☐ *Correct the issue* ☐ *Correct the isue and prevent it from coming back*

How did you first hear about The Chiropractic Place?

_____

If you were referred by someone please tell us who so we may thank them.

_____

_____ _____

(Patient or Legal Guardian Signature) *(Date)*

PATIENT HISTORY

THE CHIROPRACTIC PLACE

Name _____ *Age* _____ *Date of Birth* _____/_____/_____ *Gender* ☐ *M* ☐ *F*

Height _____ *ft.* _____ *in. Weight* _____ *lbs. Occupation* _____ *For how long?* _____ *yrs.* _____ *mos.*

1. Have you had chiropractic care before? ☐ *Yes* ☐ *No* *If yes, how recently?* _____

2. Reason for today's visit (check all the apply):

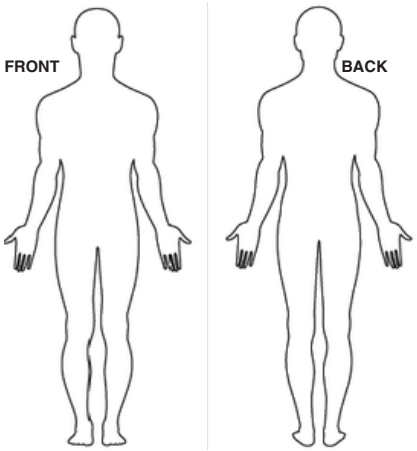
☐ *Pain* ☐ *Discomfort* ☐ *Stiffness* ☐ *Maintenance Care* ☐ *Recent Injury* ☐ *Previous Injury* ☐ *Other:* _____

3a. When did your complaint(s) first begin? _____ *3b. Today, is the condition:* ☐ *Same* ☐ *Better* ☐ *Worse*

Explain what helps and/or worsens the condition: _____

4. Where is/are your area(s) of complaint today? *Check all that apply*		*Rate pain and discomfort between 1-10* *1 = minimal* *10 = severe*	*Check off the type of Complaint*							*Frequency*	
			Radiating	*Sharp*	*Dull*	*Tingling*	*Numbnes*	*Burning*	*swollen Inflamed/*	*Constant*	*Intermittent*
☐	*Headache/Migraine*										
☐	*Neck*										
☐	*Shoulder(s)*										
☐	*Arm(s)*										
☐	*Elbow(s)*										
☐	*Wrist(s)*										
☐	*Upper Back*										
☐	*Middle Back*										
☐	*Lower Back*										
☐	*Hip(s)*										
☐	*Sciatica*										
☐	*Knee(s)*										
☐	*Ankle(s)*										
☐	*Other*										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



For Clinic Use Only: BP: _____ / _____

6. Have you experienced this/these complaint(s) before? ☐ *Yes* ☐ *No*

if yes, when? _____

7. Are you pregnant? *Yes* *No* *N/A* *If yes, how many weeks?* _____

8. Are you currently experiencing any of the following:

☐ *Nausea or vomiting* ☐ *Rapid eye movement* ☐ *Numbness on one side of the face or body* ☐ *Double vision* ☐ *Dizziness*

☐ *Fainting or lightheadedness* ☐ *Difficulty walking* ☐ *Difficulty speaking* ☐ *Headache or neck pain* ☐ *Difficulty swallowing*

(If yes to any, please describe) _____

9. Current prescriptions or over-the-countermedications: _____

PAST HISTORY: MUSCULOSKELETAL CONDITIONS (*please check all that apply*)

☐ *Headaches/Migraines*
☐ *Neck Pain/Discomfort*
☐ *Shoulder Pain/Discomfort*
☐ *Upper Back Pain/Discomfort*
☐ *Middle Back Pain/Discomfort*
☐ *Low Back Pain/Discomfort*
☐ *Inflammation/Swelling; where*

☐ *Hip Pain/Discomfort*
☐ *Sciatica*
☐ *Elbow Pain/Discomfort*
☐ *Wrist Pain/Discomfort*
☐ *Knee Pain/Discomfort*
☐ *Ankle Pain/Discomfort*
☐ *Other:* _____

☐ *Arthritis*
☐ *Fused/Fixated Joints*
☐ *Herniated Disc*
☐ *Joint Replacement*
☐ *Osteoporosis*
☐ *Osteopenia*

OTHER CONDITIONS

☐ *Cancer*
☐ *Tumors*
☐ *Stroke*
☐ *Seizure Disorders*
☐ *High Blood Pressure*
☐ *Pacemaker*
☐ *Allergies*
☐ *Other:* _____

☐ *Heart Disease*
☐ *AIDS/HIV*
☐ *Diabetes*
☐ *Hepatitis*
☐ *Tuberculosis*
☐ *Hernia*

10. Indicate if you have experienced any of the following and mark how recently.

Surgeries?	☐ *Yes* ☐ *No*	☐ *Less than 1 month*	☐ *1-6 months*	☐ *6-12 months*	☐ *More than 12 months:* _____ *yrs.*
Accidents/Broken Bones?	☐ *Yes* ☐ *No*	☐ *Less than 1 month*	☐ *1-6 months*	☐ *6-12 months*	☐ *More than 12 months:* _____ *yrs.*
Hospitalizations?	☐ *Yes* ☐ *No*	☐ *Less than 1 month*	☐ *1-6 months*	☐ *6-12 months*	☐ *More than 12 months:* _____ *yrs.*

If yes to any, list and describe:

11. Family Health History: (check all that apply) ☐ *Cancer* ☐ *Tumors* ☐ *Stroke* ☐ *Seizures* ☐ *Diabetes* ☐ *High Blood Pressure* ☐ *Heart Disease*

(Patient or Legal Guardian Signature) _____ *(Date)* _____

Do you have any other conditions we should know about or that you are currently dealing with?

Is there anything else you would like the doctor to check for you today?

Please list all current medications:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY US, ANY The Chiropractic Place CLINIC, AND THE CHIROPRACTIC PLACE CORP. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this Notice, please contact your local facility.

Who Will Follow This Notice?

1. *The Chiropractic Place*
2. *Doctors of Chiropractic who provide services to you at The Chiropractic Place; and*
3. *All employees and subcontractors of all The Chiropractic Place*

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

1. *Basis for planning your treatment;*
2. *Means of communication for or between The Chiropractic Place clinic doctors and staff, the doctors and staff of other clinics operating under The Chiropractic Place name, The Chiropractic Place, and your other health care providers, if any, that you wish us to share them with; and a*
3. *Tool for assessing and continually working to improve the care rendered.*

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES

We are required by law to:

1. *Maintain the privacy and security of your medical information;*
2. *Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;*
3. *Abide by the terms of this notice; and*
4. *Notify you if we are unable to agree to a requested restriction.*

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment.** *We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic or any other THE CHIROPRACTIC PLACE clinic where you seek treatment. For example, we may share your information with your primary care physician or other specialists upon request.*
2. **For Payment.** *We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.*
3. **For Health Care Operations.** *We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devises will have a notice posted at the clinic informing you of the use of such devices.*
4. **For Contacting You.** *We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.*
5. **Appointment Reminders.** *We may use and disclose medical information to remind you of an appointment, if applicable.*
6. **As Required by Law.** *We will disclose medical information about you when required to do so by federal or state laws or regulations.*
7. **Health Oversight Activities.** *We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.*
8. **Lawsuits and Disputes.** *If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.*
9. **Law Enforcement.** *We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.*
10. **Electronic Disclosure.** *We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically.*

NOTICE OF PRIVACY PRACTICES CONTINUED

DISCLOSURES REQUIRING AUTHORIZATION

1. **Marketing.** ***Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.***

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

1. **Right to Inspect and Copy.** ***The right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to us. You can also ask to see or get an electronic copy of health information we have about you. Ask us how to do this.***

2. **Right to Amend.** ***If you feel that medical information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us or The Chiropractic Place. To request an amendment, your request must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:***

   - ***Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;***
   - ***Is not part of the medical information kept by us or The Chiropractic Place;***
   - ***Is not part of the information which you would be permitted to inspect and copy; or***
   - ***Is accurate and complete.***

3. **Right to an Accounting of Disclosures.** ***To request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.***

4. **Right to Request Restrictions.** ***To request a restriction or limitation on the medical information we use or disclose about you for treatment OR payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. The Chiropractic Place is not required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.***

5. **Right to Revoke an Authorization.** ***There are certain types of uses or disclosures that require your express authorization. For example, we may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.***

6. **Right to Receive a Copy of this Document.** ***You have a right to obtain a paper copy of this document upon request.***

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting us.

I understand and agree to the patient privacy notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

_____

(Patient Printed Name)

_____ _____

(Patient or Legal Guardian Signature) ***(Date)***

_____ _____

(Witness / Employee Signature) ***(Date)***

INFORMED CONSENT

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and frac- tures. In addition:

1. ***While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:***
2. ***There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.***
3. ***There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.***

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alterna- tives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from THE CHIROPRACTIC PLACE.

Dated this_____ day of_____ 20_____

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis.*

***In California, please initial after reading the statement, above. Patient initials _____ Doctor initials _____**

_____

(Patient Printed Name)

_____ _____

(Patient or Legal Guardian Signature) ***(Date)***

_____ _____

(Witness / Employee Signature) ***(Date)***

TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO THE LEGAL OWNER AND OPERATOR OF THIS CLINIC LOCATION.

EXPLANATION OF SERVICES

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, dis- comfort and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO

- ***We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.***
- ***We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed doctors of chiropractic to improve motion of the body's spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.***

WHAT WE DON'T DO / LIMITATION OF SERVICES

- ***We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.***
- ***Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.***
- ***In the doctor's professional opinion, should any of our patients need additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.***

FINANCIAL RESPONSIBILITY

At the patient's discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiroprac- tic care provided to me at this location or any other clinic under The Chiropractic Place trade name based upon these guidelines.

_____ _____
(Patient Signature) ***(Date)***

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read
(Parent or Legal Guardian) ***(Child/(ren) Name)***

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____
(Parent or Legal Guardian Signature) ***(Date)***