Potter Chiropractic & Wellness Center

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CONFIDENTIAL PATIENT INFORMATION

Name_____ **Middle Initial** _____ **What do you prefer to be called?**_____

Birth Date: _____/_____/_____ **Age**:_____ **Gender:** Male Female

Address:_____ **City:**_____ **Zip Code**:_____

Home Phone (_____) _____ **Cell Phone** (_____) _____

Work Phone (_____) _____ **Email**: _____

Employer: _____ **Occupation**: _____

Work Address:_____

Marital Status Married Single Divorced Widowed

Spouse's Name _____ **# of Children** _____ **Names/Ages:**_____

How did you hear about Potter Chiropractic?

Friend/Family (Who?_____) Location Yellow Pages Other _____

Are we submitting these claims to insurance? Yes No **Name of Insurance Company**_____

Who carries this policy? Self Spouse Parent **What is this person's name?**_____ **D.O.B**.____/____/_____

Have you been to a chiropractor before? Yes No
If so, where and when were you seen?_____

What is your main area of complaint?

WHEN and HOW did your symptoms start? Please explain in detail.
On _____/_____/_____, I…

How long do you think it will take to get the results you want by receiving chiropractic care?

What would you like your health to look like in 6-12 months?

What is the one thing you could do to improve you health?

Have you been injured prior to this episode? □Car Accident Hospitalizations Surgeries **If so, please list with dates:**

Please list any family history of major illnesses or premature death: (Ex. Diabetes, Cancer, Arthritis, Heart Disease, Asthma etc.) **Who had them in your family?**

Please list any disease or disorder that you presently have, if any. (Ex. Diabetes, Cancer, Arthritis, Heart Disease, Depression, High Blood Pressure)

Please check the boxes that apply for you, both presently and in the past:

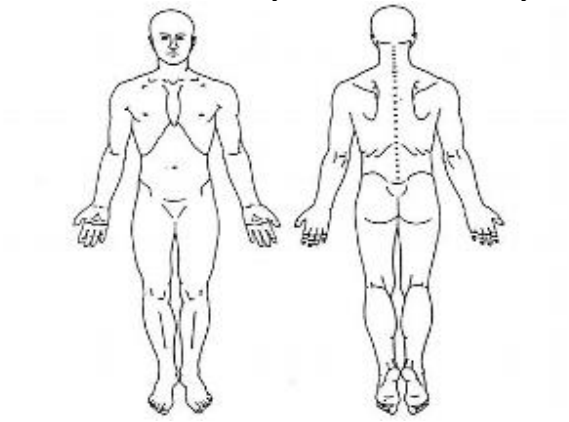
PAST	PRESENT		PAST	PRESENT
	Headache			**Fainting/visual disturbances**
	Neck Pain			**Chronic Fatigue**
	Shoulder Pain			**Chronic sinusitis**
	Pain in upper arm or elbow			**Chronic cough**
	Hand Pain			**PMS**
	Low back pain			**Loss of bladder control**
	Pain in upper leg or hip			**Abdominal pain**
	Pain in lower leg or knee			**Constipation/irregular bowel habit**
	Pain in ankle or foot			**Difficulty in swallowing**
	Jaw Pain			**Heartburn/indigestion**
	Swelling/stiffness of joints			**Dermatitis/eczema/rash**
	Nausea			**Pregnancy**
	Convulsions			**Tobacco use _____packs per day**
	Dizziness			**for the past _____ years**
	Muscular in-coordination			**Alcohol use**
	Tinnitus (ear ringing)			**Drug or alcohol dependence**
	Rapid heart- beat			**Caffeinated beverage _____ per day**
	Chest pains			**Medications (list them) _____**
	Loss of appetite			**_____**
	Broken Bones _____			

Weight change (gain or loss)_____lbs. Was this weight change intentional? Yes No

Presently I weigh _____pounds and have a height of _____feet _____inches.
My blood pressure is about _____/_____

My pain is described as: Sharp Dull Aches Soreness Weakness Tingling Stabbing Throbbing Numbness Shooting Burning

Please indicate on the body chart the location of your pain:



RATE YOUR PAIN ON A SCALE OF 1-10
(10 BEING THE WORST PAIN)

1 2 3 4 5 6 7 8 9 10

Please explain if needed:

_____

_____

_____

This pain bothers me

Constantly (76-100% of the day) Severely (51-75%) Moderately (26-50%) Slightly (0-25%)

Since your symptoms began, the pain is

Increasing Decreasing Not Changing

Have you ever had these symptoms before?

No Yes Similar, but not as bad.

Is there something that aggravates your symptoms?

Nothing Laying down Inactivity Moving/Exercise
Standing Sitting Stretching Other_____

Is there anything that temporarily eliminates your symptoms or makes them feel better?

Nothing Laying down Inactivity Moving/Exercise Sitting
Ice Heat Ibuprofen /Aspirin /Tylenol Other_____

Grade Your General Stress Level:	No stress	Minimal	Moderate	Greatly stressed
Physical Activity at Work:	Sedentary 50% of day	Light manual labor	Manual labor	
General Physical Activity:	No regular exercise	Light Exercise	Strenuous	

How many hours of sleep do you average per night? _____

What is your preferred sleeping position? _____

What is the approximate age of your mattress and pillow? _____

INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.
POTTER CHIROPRACTIC & WELLNESS CENTER uses trained personnel to assist with portions of your consultation, examination, x-rays, physical therapy application, physiotherapy application, exercise instruction, etc. Occasionally, when your chiropractor is unavailable, another qualified doctor of chiropractic may treat you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACIC CARE

1. Stroke. Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation and when occurs may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of the occurring are estimated at 1 per 400,000 treatments to 1 per 10,000,000 treatments. The most recent studies (Journal of the CCA, Vol. 37, No.2 June 1993) estimate that the incidence of this type of stroke is one in every 3,000,000 upper cervical adjustments.
2. Soreness. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort
3. Soft tissue injury. Occasionally chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon or other soft tissue injury.
4. Rib injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
5. Physiotherapy burns. Heat generated by physiotherapy modalities such as electrical muscle stimulation, ultrasound and heat therapy may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur.
6. Other problems. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic or staff promptly.
7. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to care provided, please print your name, sign and date below.
Having carefully read and initialed the above, I hereby give my informed consent to have chiropractic treatment administered.

Patients Name_____

Patient's Signature_____ Date_____

PROTECTED HEALTH INFORMATION CONSENT FORM (HIPPA)

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you ask.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations, massage and coordination of care as an example. The patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum need for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. The patient understands and agrees to allow this office to use their name for newsletters (both mailed and emailed), birthday cards, patient testimonials, referrals, appointment reminder calls and/or mailings, reactivation calls and/or mailings, etc.

I have read and understand how my Protected Health Information will be used and I agree to these policies and procedures.

Patient's Name _____

Patient's Signature_____**Date** _____