PGA Health Center

WELCOME: The doctors and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*)_____(*Middle*)_____(*Last*)_____Jr., II, III, IV
Address:_____City:_____State:_____Zip:_____
Birth Date:_____/_____/_____Age:_____Marital Status (*Circle*): Divorced Married Single Separated Widowed
Gender (*Circle*): Male / Female Home Phone: (_____)_____-_____Cell Phone: (_____)_____-_____
Social Security #:_____-_____-_____Email Address:_____@_____
Spouses Name:_____

Employer /Employment Status ☐ Employed ☐ Unemployed ☐ Full Time / ☐ Part Time Student ☐ Other
Occupation/Job Title: _____
Business Name:_____
Business Phone: (_____)_____-_____
Is it ok to contact you at work? ☐ Yes ☐ No

Emergency Contact Information

Name: (*First*)_____(*Middle*)_____(*Last*)_____Jr., II, III, IV
Address:_____City:_____State:_____Zip:_____
Relationship:_____Home Phone: (_____)_____-_____Cell Phone: (_____)_____-_____

Your Primary Care Physician_____**Physician Phone** (___)_____-_____

ACCEPTANCE AS A PATIENT: I understand and agree this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PERSONAL HEALTH HISTORY:

Have you ever had surgery or been hospitalized? *Yes / No* **List Surgeries:** _____

Please list any past serious accidents, injuries, or motor vehicle accidents with dates: _____

Please list any medications or vitamins you are currently taking: _____

Please list anything that you may be allergic to: _____

List your Chief Complaint here.

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition.

Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided: _____

Childhood Illnesses (Please list any illnesses that you have had as a child): _____

Adult Illnesses (Please list any illnesses that you have had as an adult): _____

Surgeries (Please list all surgical procedures that have had in the past): _____

Injuries (Please list any significant injuries, falls, trauma or accidents that you have had in the past. _____

Immunizations (Please list any vaccinations that you have had): _____

FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health condition.

Please describe your family history:

General Family	Alive	Deceased	Health Conditions / Diseases / Conditions
Father:			
Mother:			

SOCIAL & WORK HISTORY

This section will identify key factors and indicators about your lifestyle that may impact or contribute to your current health condition. Please check as many as apply.

Please describe you alcohol use: ☐ Social Consumption Only ☐ Beer ☐ Liquor ☐ Wine

How much alcohol do you regularly drink? _____

Have you ever used illegal substances or IV drugs ☐ Yes ☐ No

Please describe your tobacco use: ☐ None ☐ I live with a smoker ☐ I smoked/chewed but quit ☐ I currently smoke

Is there any other information that you feel would be relevant to your current condition that was not covered?

Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

_____

_____

FINANCIAL INFORMATION

Authorization for Release of Information

I authorize the release of any medical information necessary to process my insurance claims.

Authorization of Assignment

I authorize payment of medical benefits to the doctors at PGA Health Center for care rendered to me.

Reimbursement Policy and Patient Acknowledgement

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. **Please be aware that Manual therapy and Massage are typically not covered services, specifically in the same region as spinal manipulationThe charge for that is $35 above copay or coinsurance.** Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility. By signing below you acknowledge that you may refuse to sign this acknowledgment if you wish, and agree to the liability limitations explained therein. I have the right to obtain a paper copy of this notice. I acknowledge that I have reviewed this office's Notice of Privacy.

24 Hour Cancellation Policy

By signing below I understand that if I do not attend a scheduled appointment or do not provide 24 hour notice to change a scheduled appointment I may be responsible for a $50.00 service charge.

_____ _____

PATIENT SIGNATURE **DATE**

Informed Consent to Care

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 the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally 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 an instrument 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, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

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 also 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 as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____
Signature: _____
Date: _____

Witness Name: _____
Signature: _____
Date: _____

Parent or Guardian: _____
Signature: _____
Date: _____