WINKELMANN
CHIROPRACTIC & INJURY
DR. ZACHARY WINKELMANN

DATE _____

FULL NAME: _____ EMPLOYER: _____

BIRTH DATE: _____ OCCUPATION: _____

SEX: MALE FEMALE EMERGENCY CONTACT NAME: _____

ADDRESS: _____ _____

CITY/STATE: _____ RELATIONSHIP: _____

ZIP CODE: _____ EMERGENCY CONTACT PHONE: _____

PHONE: _____

EMAIL: _____

HOW DID YOU HEAR OF US (PLEASE CIRCLE ONE)? RADIO? GOOGLE? FACEBOOK? INDIVIDUAL? OTHER?

WE GIVE ACCOUNT CREDIT FOR REFERRALS, SO IF YOU REMEMBER WHO SENT YOU, WRITE THEIR NAME DOWN AND LET US SHOW OUR APPRECIATION!

NAME OF REFERRAL: _____

INSURANCE INFORMATION

DO YOU HAVE A APPLICABLE HEALTH INSURANCE, HEALTH COVERAGE, HIGH DEDUCTIBLE HEALTH PLAN OR OTHER MEDICAL COVERAGE? YES ☐ NO ☐

DO YOU HAVE AN AFLAC POLICY OR A SIMILAR SUPPLEMENTAL INSURANCE POLICY?
YES ☐ NO ☐

HAVE YOU EVER BEEN TO A CHIROPRACTOR? YES ☐ NO ☐ IF SO, WHEN? _____

IF APPLICABLE, ARE YOU PREGNANT? YES ☐ NO ☐ : IF YES, HOW MANY WEEKS? _____

ARE YOU HERE TO RECEIVE CARE FOR A CAR ACCIDENT OR WORK-RELATED INJURY? YES ☐ NO ☐

DO YOU HAVE ANY DIAGNOSED MEDICAL CONDITIONS? YES ☐ NO☐

IF YES, PLEASE DESCRIBE: _____

PLEASE SEE NEXT PAGE

FOR PROVIDER USE ONLY:

A:____ X:____ N: ____ N: ____

CHIEF COMPLAINT / RE-EVALUATION FORM

WHAT IS YOUR MAIN COMPLAINT? _____

_____

DOES THE PAIN TRAVEL (RADIATE) ANYWHERE? YES ☐ NO ☐

IF SO, WHERE? _____

WHEN DID THIS PROBLEM BEGIN? _____

PRIMARY CAUSE OF PAIN, IF KNOWN? _____

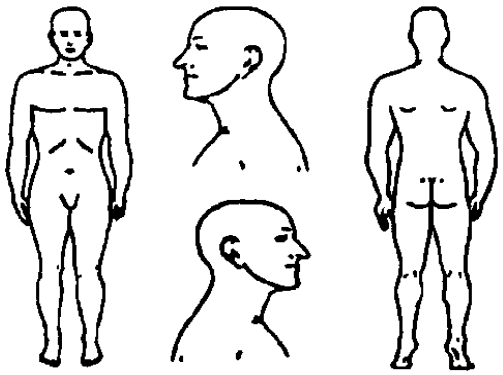
HOW OFTEN IS IT PRESENT THROUGHOUT THE DAY?

0-25% 25-50% 50-75% 75-100%

HAVE YOU EXPERIENCED THIS IN THE PAST? YES ☐ NO ☐

PLEASE MARK YOUR AREAS OF PAIN

ON THE DIAGRAM



PLEASE RATE YOUR PAIN:

RIGHT NOW:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

WHEN YOUR PAIN IS THE WORST:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

DESCRIBE YOUR PAIN (SELECT ALL THAT APPLY)

ACHING	BURNING	CRAMPING	DEEP	DULL
NUMBNESS	RADIATING	SHARP	STIFFNESS	THROBBING

WHAT MAKES THE PAIN BETTER? (SELECT ALL THAT APPLY)

HEAT	ICE	LYING	MEDICATION	MOVEMENT
NO MOVEMENT	SITTING	STANDING	STRETCHING	SUPPORT

WHAT MAKES THE PROBLEM WORSE? (SELECT ALL THAT APPLY)

BENDING	HOUSE CHORES	LIFTING	LYING	MOVEMENT
NO MOVEMENT	SITTING	STANDING	TWISTING	WALKING

PLEASE SEE NEXT PAGE

FOR PROVIDER USE ONLY:

REVIEW OF SYSTEMS

EARS AND EYES:

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR EARS AND/OR EYES? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN BELOW:

_____

_____

_____

NOSE AND THROAT:

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR NOSE AND/OR THROAT? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN BELOW:

_____

_____

_____

LUNGS, HEART, KIDNEYS AND LIVER:

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOUR LUNGS, HEART, KIDNEYS AND/OR LIVER? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN BELOW:

_____

_____

_____

BOWEL SYSTEM, URINATION AND SEXUAL FUNCTION:

HAVE YOU HAD ANY NOTICEABLE CHANGES WITH YOU BOWEL SYSTEM, URINATION AND/OR SEXUAL FUNCTION?

YES ☐ NO ☐ IF YES, PLEASE EXPLAIN BELOW:

_____

_____

_____

DO YOU SMOKE? YES ☐ NO ☐ : HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? YES ☐ NO ☐- HOW MANY PER DAY? _____

DO YOU DRINK CAFFEINE? YES ☐ NO ☐ - HOW MANY PER DAY? _____

DO YOU EXERCISE? YES ☐ NO ☐ (WHAT FORMS AND HOW OFTEN): _____

_____

PLEASE SEE NEXT PAGE

HIPAA NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. **The notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law.** It also describes your rights to access and control your protected health information (PHI). "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services. **Uses and Disclosures of Protected Health Information:** Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. **Treatment:** We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or other pre-certifications of services may require that your relevant health care information be disclosed to a health plan. **Health Care Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the reception area. We may also disclose your PHI to contact you to remind you of your appointment. **Permitted and Required Uses and Disclosures:** We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military and national security activities, worker's compensation., inmates. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: You have the right to copy and inspect your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. **You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to the requested restriction. If the physician believes that it is not in your best interest, your PHI will not be restricted. You then have the right to use another health care practitioner. **You have the right to request to receive confidential communication from us by alternative means or at an alternative location:** You also have the right to receive a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. **You have the right to have your physician amend your protected health information:** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You also have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. **We have the right to change the terms of this notice and will inform you by mail of any changes:** You then have the right to object or withdraw as provided in this notice. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please feel free to contact us in person or by phone.

INFORMED CONSENT: A chiropractic adjustment is a specific way to move the joints of the spine and body. This can be done by hand or by using an instrument. As the joints are moved, you may hear a "pop" as part of the process. This is a normal physiological reaction.
There are certain complications that can occur as a result of a spinal adjustment. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to, stroke. The most common complication or complaint following a spinal adjustment is an ache or stiffness at the site of adjustment. I am aware of these complications and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, taking a detailed clinical history from you, as well as a thorough examination. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant or suspect that you may be pregnant, please provide inform the x-ray technician.

Signature below is only acknowledgment that you have received our HIPAA Notice of Privacy Practices and Informed Consent.

SIGNATURE _____
(IF PATIENT IS UNDER 18 YEARS OF AGE, THIS FORM MUST BE SIGNED BY A PARENT OR GUARDIAN)

PRINT NAME _____ **DATE**_____