Stotler Chiropractic

Last name: _____

First name: _____

Address: _____ Phone: (h): _____

_____ (w): _____

(c): _____

Sex: M/F E-mail: _____

Occupation: _____ Marital Status: Single/Married/Div/Widow

Age: _____ Date of Birth: ____/____/____

Emergency Contact: Name: _____ Number: _____

Have you ever been to a chiropractor before?: Yes/No

Who referred you to this office?: _____

Patient File #: _____

HISTORY

Specific complaints (location): _____

How would you describe the pain: Dull Aching Sharp Burning Throbbing Tender Stabbing Numbing

How often are your symptoms present? Up to 25% 26-50% 51-75% 76-100% (Constant)

Dose the pain radiate: Yes/No

If yes, where: R/L shoulder R/L arm R/L hand/wrist R/L hip R/L leg R/L foot

Explain how and when the pain began: _____

Have you ever had this same condition in the past?: Yes/No If yes, when: _____

When are your symptoms the worst? Morning Afternoon Evening Always the same

What makes them better? Stretching Sitting Standing Rest Meds Ice/Heat P.T.
Other, please explain: _____

What makes them worse? Sitting Standing Walking Lifting Driving Other: _____

List other practitioners seen for this condition: _____

Have you noticed a change in: Bowel function Bladder function Sexual function None to all

Have you had x-rays/MRI for this condition? Yes/No If yes, where: _____

Check any of the following activities that are more difficult because of your symptoms:

___ Lifting ___ Bending ___ Walking ___ Standing ___ Stairs (Up/Down)

___ Sitting ___ Sleeping ___ Exercising ___ Driving ___ Other: _____

HISTORY OF CONDITIONS: Please check all symptoms you have experienced in the past:

___ Headaches	___ Pins & needles in legs	___ Shoulder pain	___ Loss of smell/taste
___ Neck pain	___ Pins & needles in arms	___ Elbow pain	___ Dizziness/loss of balance
___ Mid back pain	___ TMJ / jaw pain	___ Hand/wrist pain	___ High BP/heart disease
___ Low back pain	___ Numbness in fingers	___ Hip pain	___ Depression/anxiety
___ Sleeping problems	___ Numbness in toes	___ Knee pain	___ History of cancer
___ Arthritis	___ Buzzing in ears	___ Foot/ankle pain	___ Osteoporosis
___ Scoliosis	___ Asthma / allergies	___ Vision problems	___ Diabetes
___ Carpal tunnel	___ Difficulty urinating	___ Hearing loss	___ Digestive problems

Others, please list: _____

MEDICAL HISTORY:

Have you ever been hospitalized? Yes/No If yes, briefly explain: _____

Any surgeries? (Type, year): _____

Any auto accidents? (List by year): _____

List medications you are currently taking and for what: _____

What is the name of your Primary Doctor? _____ Phone number: _____

Do you smoke? Yes/No (Amount) _____ FEMALES: Are you pregnant? Yes/No/Unsure

FAMILY HISTORY: Put M for Mother, F for Father, S for Spouse and C for Children

___ Heart disease	___ Diabetes	___ Asthma	___ Circulation problems
___ Headaches	___ Back pain	___ Cancer	___ Digestive problems
___ Scoliosis	___ Disc problems	___ Osteoporosis	___ Arthritis

OCCUPATION INFO:

Job Type: Full-time / Part-time / Student / Unemployed / Retired

How long have you been at your present job?: _____ years

Work position: Seated / Standing / Other: _____

X-Ray Consent Form

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle (N/A if not applicable): _____

_____ _____

(Patient's signature) **(Date)**

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your personal health information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE: This Notice is in effect as of 10/18/2004.

By subscribing my name below, I acknowledge my understanding and agreement to its terms.

_____ _____

(Patient's signature) **(Date)**

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize _____ ("insert the Practice name") and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the Practice has provided me with specific pamphlets and other literature (and videos) and Practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. [Note: per published study in *Spine*, the Connecticut Board decision on non-materiality of stroke and other

data, chiropractors may consider deleting the reference to stroke in this sentence or with proper evidence-based references any other complications that will not be material to a patients care.]

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

Doctor's Notes:

Patient counseled by:

Discussion _____

Provision of chiropractic pamphlet _____

Viewing video _____

_____ _____
Signature of doctor Date