

— GENERAL INFORMATION —



Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Mobile Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_

Your Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Relationship: *Single*      *Married*      *Partner*      *Widow*      Children:      *Yes*      *No*

How did you find us? Who can we thank for referring you? \_\_\_\_\_

— HEALTH & LIFESTYLE PROFILE —

What is your reason for seeking services here? \_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_

What do you believe is causing your health issue? \_\_\_\_\_

What would you like to receive from your visit with us? \_\_\_\_\_

Describe your food and fluid intake. \_\_\_\_\_

Do you exercise? What do you do and how often? \_\_\_\_\_

How many hours do you sleep per day on average? Do you feel rested? \_\_\_\_\_

What do you do for play, relaxation, or fun? \_\_\_\_\_

Please list any prescription or over-the-counter drugs, vitamins or supplements. \_\_\_\_\_

\_\_\_\_\_

Is there anything else you wish to share that may help to better understand you? \_\_\_\_\_

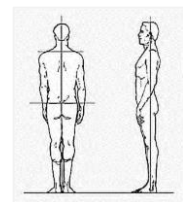
\_\_\_\_\_

-----

**(For office use only) Doctor Notes**

Oc 1 2 3 4 5 6 7 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 S LII RII Ext \_\_\_\_\_

**ROM:** Cer – F E RR LR RB LB Lum –F E RR LR RB LB



**Posture:**

— REVIEW OF SYSTEMS —

**CARDIOVASCULAR**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Stroke

**ALLERGIC/IMMUNOLOGICAL**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS

**ENDOCRINE**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Synd.

**NEUROLOGICAL**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerves
<input type="checkbox"/>	<input type="checkbox"/>	Radiating Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Balance/Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Autism/Spectrum Dis.
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD/Sensory Processing Disorder

**CONSTITUTIONAL**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level Low
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level High
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	RLS
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy/Fertility
<input type="checkbox"/>	<input type="checkbox"/>	Obesity

**MUSCULOSKELETAL**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones
<input type="checkbox"/>	<input type="checkbox"/>	Gout

**GASTROINTESTINAL**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's Disease

**PSYCHIATRIC**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder
<input type="checkbox"/>	<input type="checkbox"/>	OCD
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Affective Dis.

**EAR/NOSE/THROAT**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss

**RESPIRATORY**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	COPD

**GENITOURINARY**

<u>Present</u>	<u>Past</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems

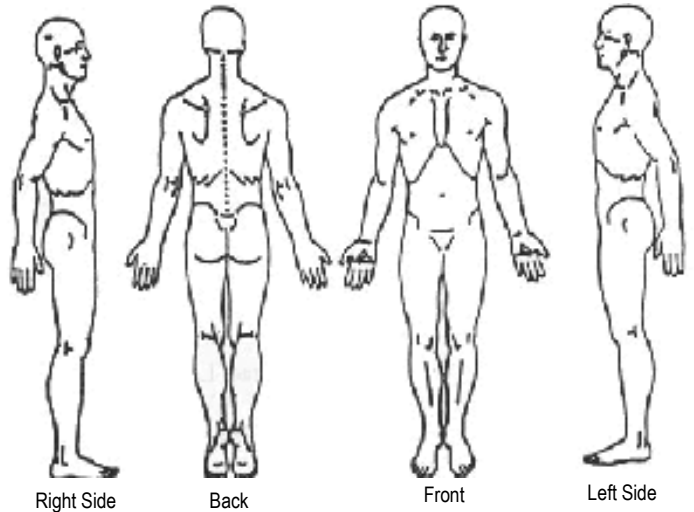
Other conditions or previous surgeries: \_\_\_\_\_

— HEALTH EVALUATION & PAIN DIAGRAM —

The following seven categories help shape your health and life satisfaction. Please indicate your current satisfaction in each category with an (X) on the lines below.

	<u>LOW</u>	<u>HIGH</u>
PHYSICAL	.....	
MENTAL	.....	
SPIRITUAL	.....	
FAMILIAL	.....	
SOCIAL	.....	
FINANCIAL	.....	
VOCATIONAL	.....	

Mark on diagram below where you may have pain or other symptoms.



## Voicemail Preferences

I agree that voice messages can be left on any of the phone numbers listed on first page of this form with details about my appointments and chiropractic care.

## Email Preferences

Email Address: \_\_\_\_\_

I agree to receive personal emails regarding my care, appointments, and payments.

I would like to receive, or continue receiving, monthly email newsletters with health tips, research, recipes and information about Thrive Chiropractic events. I can easily unsubscribe at any time if I do not find these newsletters valuable.

## Text Message Reminders

I would like to receive, or continue receiving, text message reminders 24 hours in advance of my scheduled appointments.

## Cancellation Policy

I understand that Thrive Chiropractic requires 24-hour notice for canceling appointments. I may be charged \$45 for any missed appointments if I fail to show up or fail to give 24-hour notice.

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 an “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:** \_\_\_\_\_

**Parent / Guardian:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Date: \_\_\_\_\_

You may refuse to sign this acknowledgement. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

\_\_\_\_\_

\_\_\_\_\_

**Print** Patient Name

**Signature** of Patient or Guardian

\_\_\_\_\_

\_\_\_\_\_

Legal Representative / Guardian

Relationship to Patient

\_\_\_\_\_

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment \_\_\_\_\_

I could not communicate with the patient \_\_\_\_\_

The patient refused to sign \_\_\_\_\_

The patient was unable to sign because \_\_\_\_\_

Other (please describe) \_\_\_\_\_

Signature of Privacy Officer: \_\_\_\_\_