PROGRESSIVE CHIROPRACTIC

New Patient Paperwork

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: □ M □ F Age: _____ Birthdate: _____

Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Email: _____ Newsletter? □ Y □ N

*Person to contact in an emergency (Name, Phone #, Relationship to Patient):

_____

Chief Complaint (Please be concise & thorough)

Chief Complaint (Reason you are seeking Care): _____

_____

When/How often are you experiencing this problem? _____

_____

Does the pain/problem radiate or travel anywhere? _____

_____

Has the problem changed since it started? If so, how? _____

_____

What makes it better? What makes it worse? _____

_____

When did this start? Have you ever had this issue before? _____

_____

What other therapies/ have you tried for this problem? _____

_____

Have you had any current tests/exams/imaging done? _____

_____

What daily activities is this affecting or preventing? _____

_____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain(Discomfort)	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain(Discomfort)**

PROGRESSIVE CHIROPRACTIC

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living & School
***Please check all the daily living activities that cause you pain/discomfort because of your chief complaint**

□ Dressing	□ Sitting in a restaurant	□ Opening a jar
□ Putting on pants	□ Shopping	□ Lifting a pan when cooking
□ Putting on shoes	□ Driving to/from work	□ Using my home computer/devices
□ Tying my shoes	□ Sitting in church	□ Climbing stairs
□ Putting on a shirt	□ Playing with my children	□ Going down stairs
□ Drying my hair	□ Caring for my children	□ Turning head left or right
□ Combing my hair	□ Bending at the waist	□ Holding up head all day
□ Washing my hair	□ Sitting in a movie theater	□ I have pain sitting doing nothing
□ Taking a bath	□ Exercise	□ Writing/Reading
□ Leaning forward	□ Eating	□ Life has become a chore just to do normal things
□ Laying in bed	□ Stooping	□ Life has become depressing living like this
□ Sitting in my favorite chair	□ Squatting down	□ other: _____
□ Sleeping	□ Kneeling	□ _____
□ Going out with my friends	□ Brushing my teeth	□ _____

Other Complaints (Please circle any you are experiencing)

Headache	Feet/Hands Cold	Unbalanced
Migraines	Depression	Fainting
Loss of memory	Rib pain	Blurred/Double vision
Dizziness/Vertigo/Meniere's	Nervousness/Anxiety	Irritability
Ears ringing/buzzing	Eye strain/pain	Sleep problems
Upper/Mid/Lower back pain	Shortness of breath	Loss of smell
Post Concussion/Whiplash	Fear/Confusion	Chest pain
TMJD/Jaw	Mental Dullness	Neck Pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left
Other_____	Other_____	Other_____

PROGRESSIVE CHIROPRACTIC

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Occupation: _____

If you could wave a magic wand and get rid of one complaint forever, what would it be and why?

_____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Exercise: ___ Yes ___ No If yes, How often per week _____ and duration _____

Diet ___ Yes ___ No If yes, Number of meals per day _____

Pregnancy (*Females)*: Please circle answer

yes no

Surgical History and Medical Implants: Please list ALL previous surgery/implants and the date on which it was performed:

Surgery _____ Date _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

History of Motor Vehicle Collision/Falls/Sports Injuries: Please list with the approximate date on which it happened:

Injury _____ Date _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical alerts: Please list any medical alerts you may have:

_____

PROGRESSIVE CHIROPRACTIC

PATIENT INSURANCE INFORMATION:

Do you have an open case auto claim that you expect to pay for care? □ Yes □ No
Do you have Medicare Part B benefits? □ Yes □ No

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Musculoskeletal Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis □ other: _____

Neurologic Disorders

□ stroke or TIA □ parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ anxiety and/or panic □ difficulty concentrating □ epilepsy or seizures □ other: _____

Ear, Nose, Throat Disorders

□ chronic ear infections □ dizziness □ postnasal drip
□ difficulty swallowing □ ringing in the ears □ other: _____

Cardiovascular / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack, myocardial infarction □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ bleeding problems □ other: _____

Respiratory - Lungs / Pulmonary – Breathing Disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease □ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Endocrine & Metabolic Disorders

□ hyperthyroidism □ Diabetes x _____ years □ increase urination
□ hypothyroidism □ excessive thirst □ feeling hot or cold all the time
□ high cholesterol or lipids □ cushing's syndrome □ other: _____
Cancer : any type -- please specify _____

Dermatological & Hemopoietic Disorders

□ change in hair or nails □ skin disorder _____ □ excessive hair loss
□ easy bruising □ psoriasis □ skin cancer
□ sickle cell disease □ any skin ulcer □ skin rashes
□ eczema □ gum bleeding, tooth abscess, gingivitis □ other: _____

Other medical problems NOT included above (explain) _____
_____

Family History:
Please indicate with an "X" any significant family medical history or problems.

□ asthma	□ tuberculosis	□ sleep apnea
□ COPD or Emphysema	□ other lung :_____	
□ heart attack, myocardial infarction		□ congestive heart failure
□ irregular heartbeat, arrhythmia		□ bleeding problems
□ other heart :_____		
□ peripheral neuropathy	□ MS or Parkinson's	□ other neuro :_____
□ osteoarthritis	□ Lupus	□ gout
□ rheumatoid arthritis	□ Other bone & joint: _____	
□ acid reflux, GERD	□ inflammatory bowel disease	
□ hepatitis - Type _____		
□ liver disease	□ other GI :_____	
□ kidney problems	□ dialysis, kidney failure	
□ diabetes	□ psoriasis	□ high cholesterol or lipids
□ thyroid problems	□ sickle cell disease	□ any skin ulcer
□ Malignant hyperthermia		

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

INDICATE PAST CHIROPRACTIC CARE(Please circle all that applies):

None	Traditional Chiropractic	NUCCA	Other Upper Cervical Care

PRIMARY CARE PROVIDER:

Provider Name/Address/Phone: _____

_____

PLEASE LIST ALL OTHER HEALTHCARE PROVIDERS:

Dentist: Name/Address/Phone: _____

_____

Neurologist: Name/Address/Phone: _____

_____

Specialist: Name/Address/Phone: _____

_____

Physical Therapist: Name/Address/Phone: _____

_____

Massage Therapist: Name/Address/Phone: _____

_____

PROGRESSIVE CHIROPRACTIC

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. We will assess your specific condition, your overall health, and, in particular, your spinal health. This will assist us in determining if NUCCA care is needed, or if any further examinations or studies are needed before initiating care. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a program of care prior to any treatment.

We do not offer to diagnose or provide care for any disease or condition other than your Subluxations. However, if during the course of evaluation and care we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

Patient
Name:_____

Patient
Signature:_____Date:_____

Legal Guardian Signature:_____

Do not Write Below this line **Office use Only**

Witness Signature (Office Staff): _____Date:_____

PROGRESSIVE CHIROPRACTIC

PRIVATE HEALTH INFORMATION (PHI)

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. We may use or disclose your PHI for workers compensation and similar programs. In direct reference to § 164.506 Uses and disclosures to carry out treatment, payment, or health care operations, the following will apply:

(a) *Standard: Permitted uses and disclosures.* Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b*) Standard: Consent for uses and disclosures permitted*. (1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.(2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under § 164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.

(c) *Implementation specifications*: Treatment, payment, or health care operations.(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.(2) A covered entity may disclose protected health information for treatment activities of a health care provider.(3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or(ii) For the purpose of health care fraud and abuse detection or compliance.(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree with your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised policy as stated in this notice.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Patient or Legal Guardian: _____ Date: _____