Personal Information

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:**

Last Name:

Address: | **Date of Birth:** | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: | **Home Phone #:** | **E-mail Address:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse Name: | **Contact Phone #:**

Emergency Contact *(if different from spouse)* | **Contact Phone #:**

Employment Status: ☐ Full-Time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student

Employer Name: | **Work Phone #:**

Family Physician: | **Contact Phone #:**

Person Responsible for Bills *(if different from personal information)*

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:**

Last Name: | **Social Security:**

Address: | **Date of Birth:** | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: | **Home Phone #:** | **E-mail Address:**

Employer Name: | **Work Phone #:**

Reason for Your Visit to Our Office

☐ Auto Accident ☐ Independent Personal Health Reasons ☐ Nutrition ☐ Wellness Care (RRT) ☐ Massage Therapy

How Did You Hear About Us

Friend Refered Me (please write down their name):

☐ Internet/Website ☐ Doctor Referred ☐ Friend/Family ☐ Insurance Agent Refered ☐ Lawyer Refered

Complaint History

Patient Name _____ **Date** _____

Current Health Complaint: ***(Give a brief, detailed description of the problem you are currently experiencing)***

When did this problem start (date)? | How did it start?

How often do you feel it? ☐ 0-25% of the time (intermittent), ☐ 26-50% of the time (occastional), ☐ 51-75% of the time (frequently), ☐ 76-100% of the time (constantly)

What does it feel like? *(Please check all that apply):*

☐ Achy ☐ Burning ☐ Congestion ☐ Cramping ☐ Crawling ☐ Dull ☐ Electric-like ☐ Fatigue ☐ Itchy ☐ Nagging ☐ Numb
☐ Pounding ☐ Pressure ☐ Pulling ☐ Sharp ☐ Shooting ☐ Sore ☐ Spasm ☐ Stabbing ☐ Stiff ☐ Stressed ☐ Tight ☐ Tingling
☐ Throbbing ☐ Weakness ☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric-like with motion

Does it radiate to anywhere? *(please describe)* :

On a Scale of 0 to 10 - where 0 is no pain and 10 is the worst pain ever - please circle the numbers that apply:
Level you feel the most: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the best: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the worst: 0 1 2 3 4 5 6 7 8 9 10

Does anything make it feel worse? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Twisting right ☐ Twisting left
☐ Climbing stairs ☐ Coughing ☐ Driving ☐ Exercising ☐ Kneeling ☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side
☐ Carrying ☐ Lifting ☐ Pushing ☐ Pulling ☐ Running ☐ Sleeping ☐ Sneezing ☐ Sitting ☐ Standing ☐ Straining ☐ Stretching
☐ Walking ☐ Work duties ☐ Feels worse in the A.M. ☐ Feels worse in the P.M. ☐ Nothing specific makes it feel worse
☐ Other *(please describe)* :

Does anything make it feel better? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Resting ☐ Sleeping
☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side ☐ Massage ☐ Moving around ☐ Sitting ☐ Standing ☐ Walking
☐ Stretching ☐ Icing the symptomatic area ☐ Heat on the symptomatic area ☐ OTC Medication ☐ Prescription medication
☐ Feels better in the A.M. ☐ Feels better in the P.M. ☐ Nothing specific makes it feel better
☐ Other *(please describe)* :

Have you received **previous treatment** for this condition? From who? ☐ Yes, ☐ No
☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:

Did the treatment help?
☐ It improved ☐ Got Worse ☐ There was no change

Patient Name _____ **Date** _____

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints
- ☐ My current complaints DID exist before, but had been dormant
- ☐ My current complaints ALREADY existed and were worsened

Has your Health History Contributed to Your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms
- ☐ My history HAS NOT contributed to my current symptoms
- ☐ I'm NOT SURE if my history has contributed to my symptoms

General Health History

Please select any of which applies to your current or past health history. Y = YES / N = NO

Do you have or get any of the following:

Headaches? ☐ Y ☐ N
How often _____ x's ☐ Day ☐ Week ☐ Month ☐ Year

Chest pains or tightness? ☐ Y ☐ N
How often _____ x's ☐ Day ☐ Week ☐ Month ☐ Year

Dizziness / Light headedness? ☐ Y ☐ N
How often _____ x's ☐ Day ☐ Week ☐ Month ☐ Year

High Blood Pressure? ☐ Y ☐ N
How long? _____ x's ☐ Days ☐ Weeks ☐ Months ☐ Years

Do lights bother your eyes? ☐ Y ☐ N
How often _____ x's ☐ Day ☐ Week ☐ Month ☐ Year

Have you ever been officially diagnosed with any of the following?

Rheumatoid arthritis ☐ Y ☐ N

Osteoarthritis ☐ Y ☐ N

Diabetes:

- **Insipdidus** ☐ Y ☐ N
- **Mellitis - Type I** ☐ Y ☐ N
- **Mellitis - Type II** ☐ Y ☐ N

AIDS / HIV ☐ Y ☐ N

TIA's ☐ Y ☐ N

Stroke ☐ Y ☐ N

Women - Are you pregenant or think you might be pregnant?
☐ Y ☐ N

Social History

Please indicate beside each activity whether you engage in it?
O = Often, S = Sometimes, N = Never

Exercise and Activity (pick one)

Vigorous exercise	O	S	N
Moderare exercise	O	S	N
Low intensity exercise	O	S	N
No Regular Exercise	☐		

Personal and Social Habbits (circle what applies)

Alcohol use:	None	1 - 2	2 - 3	3 - 4	4 - 5	5 - 6	6 or more	**(times/per week)**
Tobacco use:	None	1 - 2	2 - 3	3 - 4	4 - 5	5 - 6	6 or more	**(packs/per week)**
Caffeine use:	None	1 - 2	2 - 3	3 - 4	4 - 5	5 - 6	6 or more	**(drinks/per day)**

Average hours of sleep per 24hr period? 1 - 2 2 - 3 3 - 4 4 - 5 5 - 6 6 - 7 7 - 8 8 - 9 9 or more **(avrg./per 24hrs)**

Do you experiences HIGH STRESS activity or work? Never Rarely Occastionally Frequently Usually Constantly

Prior Treatment(s)

Have you seen anyone else for your current sypmtoms?

Please select all that apply: Chiropractor Osteopath Naturopath Massage therapist Medical doctor Physical Therapist

Other: _____

Are you under the care of another physician? Who? _____

Please list all medications that you are taking:

_____

_____

Please list all previous surgeries and/or hospitalizations and the year of occurance (including C-sections / child birth)**:**

_____

_____

INFORMED CONSENT

(Please Read Carefully Before Signing.)

As will all things physical, when you engage in the treatment of soft (muscles, ligaments, etc.) and osseous (bone) tissues, there are risks in making changes to those tissues since they have been in a state of dysfunction for an undetermined amount of time. At Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic, we strive to provide the greatest physical health care available. Our methods and techniques allow us greater flexibility in our treatments and minimize the risks that can be found in traditional healthcare facilities. However, there are always risks in any treatment you decide to receive. This document outlines the possible risks of the type of care that we provide in this office. Please read all the information in this document before signing and accepting care.

- **The chiropractic adjustment:**
  The doctor will use his hands or a mechanical adjusting instrument, upon your body, in such a way, as to move your joints when necessary. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel or sense a movement of the joint. It is not uncommon to feel some stiffness and/or soreness in the adjusted areas following the first few days of treatment.

- **The material risks inherent in chiropractic adjustment:**
  There are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and/or separations and/or rib fractures. In rare instances, some types of manipulation of the neck have been associated with injuries to the arteries (known as vertebral artery dissection) in the neck leading to or contributing to serious health complications including (but not limited to) stroke.

- **The probability of risks occurring:**
  Receiving a fracture from treatment is an extremely rare occurrence and generally results from some underlying pathological weakness of the bones. The different causes of stroke have been the subject of tremendous disagreement within the medical community for decades. One prominent authority claims that there is at most a one-in-a-million chance of such an outcome while utilizing the chiropractic adjustment in the cervical spine. As a policy, to reduce your risk, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The possibility of having the other complications that are list above in the *material risks section* also generally described as occurring "rarely."

- **Ancillary (Modality) treatments:**
  In addition to chiropractic adjustments, we use the following treatments which have been listed with their known risks:
  - ***Needle acupuncture*** - infection is rare but possible. We use single use, sterile needles to reduce this risk.
  - ***Electrical stimulation*** - Skin burns and soft tissue irritation.
  - ***Infrared heat (moxa) therapy*** - Skin burns.
  - ***Physiotherapy*** - Used to rehabilitate fascia, muscles, ligaments and nerves. Possible side effects are:
    - Muscle strain and/or reinjury of presented complaint(s)
    - Ligamentous strain, sprain or reinjury
    - Possible reinjury of presented complaint(s)
  - ***Manual therapy*** - Used to release muscle tension, skeletal subluxation and toxic metabolites. This can cause muscle stiffness and aches as well as headaches and/or **bruising of the soft tissues**. Drinking plenty of water should aid in a quick recovery if these symptoms arise.
  - ***Neuromuscular Therapy*** - Findings are similar to Manual Therapy.

- **The availability and nature of other treatment options:**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest or exercise, etc.
  - Prescription drugs such as anti-inflammatory, muscle relaxants and painkillers recommended and provided by your MD.
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications can produce undesirable side effects. If complete recovery is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Available (online) literature describes the highly undesirable effects from long term use of over-the-counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors. Additionally, there is no guarantee of outcome with surgery.

- **The risks and dangers attendant to remaining untreated:**
  Remaining untreated allows the formation of adhesions, a continual increase of soft tissue inflammation and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

- **Treatment Outcome Possibilities:**
  The treatments provided in this clinic have proven to be effective in relieving a variety of illnesses and health problems. The outcome of treatments provided have the following possibilities: *the symptoms or illness you have sought care for may improve, may remain unchanged, or have the possibility of getting worse.* We strive to ensure that your care is complete and that you will be satisfied with your outcome.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED ABOVE.
By signing this informed consent, you agree that you have read ALL (in its entirety) or that someone has read to you ALL (in its entirety) the above explanation(s) of the nature of any treatments provided and possible risks with undergoing and/or receiving chiropractic treatment and modality treatments. By signing below, you are stating that you also understand the inherent risks of refusing chiropractic treatment and modality treatments provided by the staff and/or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
By signing below, I state that I have weighed the risks involved in undergoing and/or receiving treatment and assume the risk in receiving any and all chiropractic treatment and/or all modality therapies and I have decided it is in my best interest to undergo and/or receive any and/or all said treatment as well as any or all other treatments and services offered and provided by the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
Having been informed of the risks, I hereby give my consent and assume any and/or all the risks of receiving any and/or all treatment deemed necessary the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic for any reason. I understand that if I have any questions regarding treatment and/or services, I may ask the doctor and/or staff at any time for an explanation for reasons and purposes of treatment or services provided.

_____ _____
Patient Printed Name Date

_____
Patient Signature

_____
(Signature of Parent or Guardian or Responsible Party)

HIPAA PRIVACY NOTIFICATION & PRACTICE REQUIREMENTS

Arbor Creek Health & Wellness (Office):

(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, (the office) 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 the Privacy Notice.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire 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.
(g) Will provide to you, for your convenience, the office's HIPPA Compliance book upon request.
(h) Additionally, the Patient Rights & Responsibilities document explains the Office's responsibilities toward the patient and the patient's toward the office. Every patient will be given this document for review at their leisure.

EFFECTIVE DATE:
This Notice is in effect as of 3/18/09

PATIENT ACKNOWLEDGEMENT:
By subscribing my name below, I acknowledge having read the Notice; I understand it and agree to its terms.

_____ _____
Signature of Patient, Parent/Guardian or Responsible Party **Date**

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment Patient's acknowledgment of the notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other
Details:

_____ _____
Signature of Practice Date