OQUIST FAMILY CHIROPRACTIC, PC

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WELCOME TO OUR OFFICE

WE ARE SO GLAD THAT YOU ARE HERE TODAY. IF YOU HAVE ANY QUESTIONS CONCERNING OUR POLICIES, FORMS, OR PROCEDURES, JUST ASK. IT IS OUR PLEASURE TO HELP YOU.

CONFIDENTIAL PATIENT INFORMATION

DATE: _____ WERE YOU REFERRED TO THIS CLINIC? _____ IF SO, BY WHOM? _____

HAVE YOU EVER SEEN A CHIROPRACTOR? _____ IF SO, WHO? _____

NAME: _____ SEX: M OR F AGE: _____ BIRTH DATE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MAILING ADDRESS: _____ CITY/STATE/ZIP: _____

MARITAL STATUS: _____ NO. OF CHILDREN: _____ OCCUPATION: _____

EMPLOYER: _____

NAME & PHONE NUMBER OF NEAREST RELATIVE (OTHER THAN SPOUSE):

_____

PERSON OR INSURANCE RESPONSIBLE FOR PAYMENT: _____

OUR PRIVACY PRACTICES:

IN OUR OFFICE, ALL HEALTH INFORMATION IS CONSIDERED CONFIDENTIONAL AND WE ARE CAREFUL ABOUT HOW WE USE IT. THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ ABOUT YOUR HEALTH INFORMATION AND LET US KNOW IF YOU HAVE ANY QUESTIONS.

WE MAY SHARE YOUR HEALTH INFORMATION TO:

- TREAT YOU
- COLLECT PAYMENT
- RUN OUR OFFICE
- INFORM YOU ABOUT OTHER SERVICES
- DISCUSS YOUR CASE WITH FAMILY
- DO RESEARCH
- INCLUDE YOU IN CARE CLASSES
- THANKYOU FOR REFERRING OTHER PATIENTS

WE MAY SHARE YOUR HEALTH INFORMATION FOR:

- HEALTH AND SAFETY REASONS
- REPORTING TO LAW OFFICIALS
- REPORTING VICTIMS OF ABUSE
- COURT HEARINGS AND FILINGS
- REPORTING TO WORKER'S COMPENSATION

YOU HAVE THE RIGHT TO:

- REQUEST A COPY OF YOUR HEALTH RECORD
- REQUEST A LIST OF WHOM WE SHARE YOUR HEALTH INFORMATION WITH
- ASK US TO LIMIT THE INFORMATION WE SHARE
- ADVISE OUR MANAGEMENT IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED
- REQUEST CONFIDENTIAL COMMUNICATIONS
- AMEND YOUR PROTECTED HEALTH INFORMATION

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FUTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE NECESSARY FORMS AND REPORTS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT. HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR SERVICES RENDERED ME WILL BE IMEMDIATELY DUE AND PAYABLE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM AS MENTIONED ABOVE.

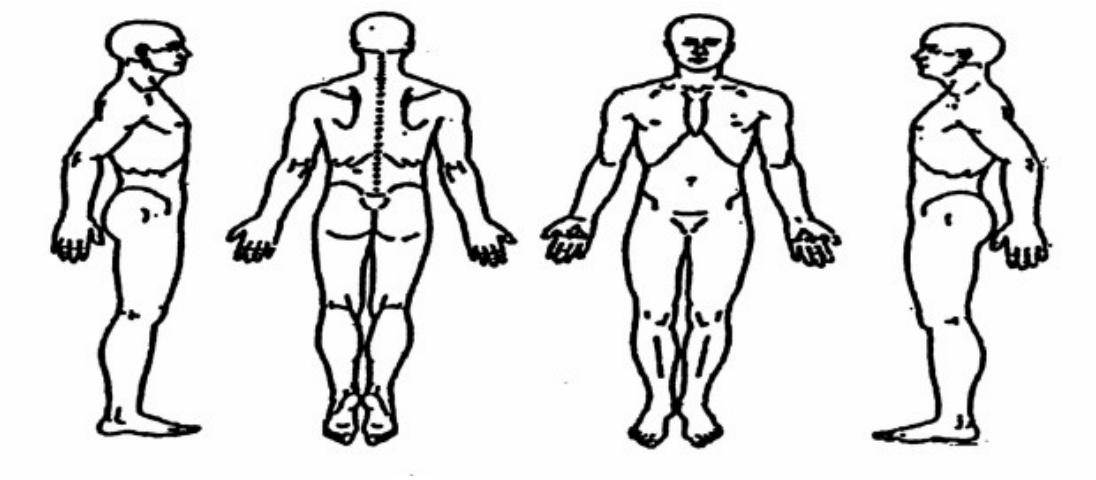
PATIENT OR GUARDIAN SIGNATURE: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Personal Injury

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□Stiff □

Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. **What is your: Height_____ Weight _____**

16. **How would you rate your overall Health?**

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. **What type of exercise do you do?**

□ Strenuous □ Moderate □ Light □ None

18. **Indicate if you have any immediate family members with any of the following:**

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. **For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Infertility
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Irregular Bowel movements
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Irregular monthly cycles
□	□ Joint Pain/Stiffness	□	□ Ulcers	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Acid Reflux/ indigestion	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. **List all surgical procedures you have had:**

_____

21. **What activities do you do at work?**

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

22. **What activities do you do outside of work?**

_____

23. **Have you ever been hospitalized?** □ No □ Yes if yes, why

_____

24.

25. **Have you had significant past trauma?** □ No □ Yes

If yes, explain_____

26. **Is there anything else we should know about your health history?**

_____

Consent to Chiropractic Treatment

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, and soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.
Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition. Possible risks and complications associated with these procedures as follows:

- **Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.
- **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- **Fracture/Joint Injury**: I further understand that in isolated cases, underlying physical defects, deformities, or pathologies like weak bones from osteoporosis, may render the patient susceptible to injury. When Osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with caution.
- **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions used, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the counter medications, possible surgery, and non-treatment. Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE:_____

DATE: _____