Optimal Spine Chiropractic Application for Care

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Drs. Mark & Jen Kordonski

PATIENT INFORMATION

Name: _____

Nickname:_____

Date Of Birth: _____

Address: _____

City:_____State:_____Zip: _____

Please Check

Smoker? ❑ Current ❑ Past ❑Never

❑ Male	❑ Right handed	❑ Married
❑ Female	❑ Left handed	❑ Single

Occupation:_____

Employer: _____

Work Duties:_____

Spouse/Partner:_____

Children's Name & Ages:_____

_____

CONTACT INFORMATION

Home Phone: _____

Work Phone: _____

Cell Phone:_____

E-mail: _____

Emergency Contact-Name & Number: _____

ACCIDENT

Is this condition due to an accident? ❑ Yes ❑ No

Type of accident: ❑ Auto ❑ Work ❑ Home

Date of Accident: _____

INSURANCE INFORMATION

Subscriber's Name: _____

Relationship To Patient:_____

Birth date: _____

HEALTH HISTORY

Reason for visit: describe **chief complaint** and any **additional** problems. Rate the symptoms on a scale of **1-10 (10 being the worst)**

1. _____ _____ (1-10)
2. _____ _____ (1-10)
3. _____ _____ (1-10)
4. _____ _____ (1-10)

When did the symptoms first appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unsure

Family members with similar symptoms:_____

Date of last Chiropractic visit: _____ Dr.'s name:_____

Other Doctors you have seen for this symptom:_____

Past surgeries & dates: _____

List X-rays in past 2 years: _____

Medications you currently take: _____

Is there any chance you are pregnant? ❑ No ❑ Yes Due Date: _____

Whom may we thank for referring you?_____

I certify the above information is true and accurate to the best of my knowledge.

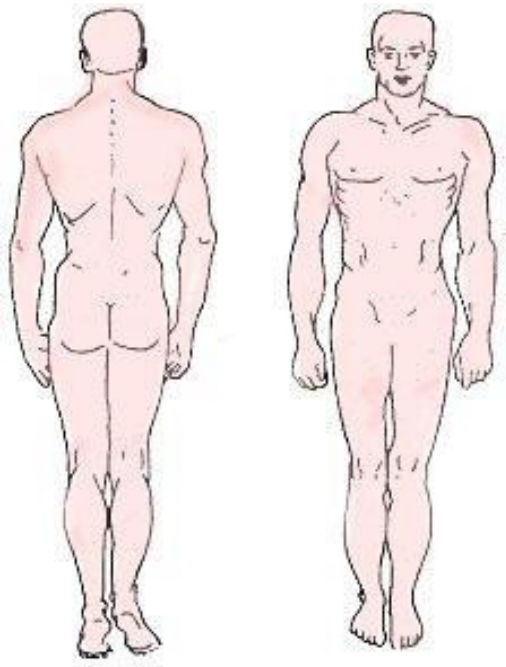
Signature: _____ **Date:** _____

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check:*

Condition, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Heart Problems	❑	❑
Ringing In Ears	❑	❑
Cough	❑	❑
Chest Pains	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin Conditions	❑	❑
Other	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank You for being Complete and Thorough

Family Health History

Please list ALL known diagnosed health conditions: (i.e. arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol)	**Relationship to you:** (i.e. mother, father, sister, brother, aunt, uncle, maternal & paternal grandparents)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Signature: _____ **Date:** _____

PRIVACY NOTICE

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review carefully.

Disclosure of your protected health information without authorization is strictly limited in defined situations that include emergency care, quality assurance activities and public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practical operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in this office.

You may file a complaint about privacy violations by contacting our Office Manager.

Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/ INTENT TO PAY DOCTOR

I hereby assign all medical benefits available for the services rendered by Optimal Spine Chiropractic. I authorize direct payment of these services to the above office address.

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 or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____