

CURRENT CONCERNS:

REASON(S) FOR SEEKING TREATMENT: _____

HISTORY OF INJURY TO THE AREA? Y N

IF YES, PLEASE EXPLAIN: _____

DATE OF INJURY/ONSET OF SYMPTOMS: ____/____/____

CURRENT PAIN LEVEL: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE)

DESCRIPTION OF PAIN: ACHING SHARP BURNING NUMBNESS TINGLING

SELF-CARE: ICE HEAT OTHER _____

OTHER HEALTHCARE PROVIDERS SEEN FOR THIS CONCERN: Y N

IF YES, NAME OF PRACTITIONER _____ APPROXIMATE DATE OF TREATMENT ____/____/____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? Y N

IF YES, APPROXIMATE DATE OF LAST TREATMENT ____/____/____

GENERAL HEALTH HISTORY:

CURRENT HEIGHT: _____ CURRENT WEIGHT: _____

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH HISTORY...

CONGENITAL HEART DEFECT

CANCER

DIABETES

KIDNEY PROBLEMS

SCOLIOSIS

ASTHMA

NECK PAIN

BACK PAIN

HEADACHES

ARTHRITIS

HIGH BLOOD PRESSURE

ARTIFICIAL JOINTS

CONSTIPATION

DIARRHEA

DIGESTIVE PROBLEMS

SLEEPING PROBLEMS

OTHER CONDITIONS _____

ALLERGIES/SENSITIVITIES _____

MEDICATIONS _____

VITAMINS/SUPPLEMENTS _____

ACCIDENTS/INJURIES _____

PRIMARY CARE PHYSICIAN _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING: ASHLEY L. WAGNER TELEPHONE: 701-557-7455

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE

I, _____ (PRINT), HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT (IF APPLICABLE): _____

AUTHORIZED PROVIDER REPRESENTATIVE SIGNATURE: _____



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

THERE ARE RISKS AND POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC MANIPULATIVE TREATMENT USED BY DOCTORS OF CHIROPRACTIC. IN PARTICULAR YOU SHOULD NOTE:

1. WHILE RARE, SOME PATIENTS MAY EXPERIENCE SHORT TERM AGGRAVATION OF SYMPTOMS, OR MUSCLE AND LIGAMENT STRAINS OR SPRAINS AS A RESULT OF CHIROPRACTIC MANIPULATIVE TREATMENT TECHNIQUES. ALTHOUGH UNCOMMON, RIB FRACTURES HAVE ALSO BEEN KNOWN TO OCCUR FOLLOWING CERTAIN CHIROPRACTIC PROCEDURES;
2. 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 TREATMENT AND THE OCCURRENCE OF STROKE. STUDIES SUGGEST THAT PATIENTS MAY BE CONSULTING MEDICAL DOCTORS AND CHIROPRACTORS WHEN THEY ARE IN THE EARLY STAGES OF A STROKE. IN ESSENCE, THERE IS A STROKE ALREADY IN PROGRESS. HOWEVER, YOU ARE BEING INFORMED OF THIS REPORTED ASSOCIATION BECAUSE A STROKE MAY CAUSE SERIOUS NEUROLOGICAL IMPAIRMENT, OR EVEN DEATH. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH A CERVICAL ADJUSTMENT IS EXTREMELY REMOTE;
3. THERE ARE RARE REPORTED CASES OF DISC INJURIES IDENTIFIED FOLLOWING CERVICAL AND LUMBAR SPINAL ADJUSTMENT, ALTHOUGH NO SCIENTIFIC EVIDENCE HAS DEMONSTRATED SUCH INJURIES ARE CAUSED, OR MAY BE CAUSED BY SPINAL ADJUSTMENTS OR OTHER CHIROPRACTIC TREATMENT;
4. THERE ARE INFREQUENT REPORTED CASES OF BURN OR SKIN IRRITATION IN ASSOCIATION WITH THE USE OF SOME TYPES OF ELECTRICAL THERAPY OFFERED BY SOME DOCTORS OF CHIROPRACTIC.

I ACKNOWLEDGE I HAVE READ THIS CONSENT AND I HAVE DISCUSSED, OR HAVE BEEN OFFERED THE OPPORTUNITY TO DISCUSS WITH MY CHIROPRACTOR THE NATURE AND PURPOSE OF CHIROPRACTIC TREATMENT IN GENERAL, AND THE CONTENTS OF THIS CONSENT.

I CONSENT TO THE CHIROPRACTIC TREATMENT RECOMMENDED TO ME BY MY CHIROPRACTOR, INCLUDING ANY RECOMMENDED SPINAL ADJUSTMENTS. I INTEND THIS CONSENT TO APPLY TO MY PRESENT AND FUTURE CHIROPRACTIC CARE.

PATIENT/LEGAL GUARDIAN NAME (PRINT): _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PROVIDER ACKNOWLEDGEMENT OF CONSENT: _____