Welcome to The Chiropractor at Castlebury

Patient ______________________________ **Date** ______________________

Address ______________________________ **City** ______________________

State ______ **Zip** ________ **Who may we thank for referring you?** ______________________

Home (____) ____________ **Cell (____)** ______________ **Work(____)** ______________

Email ______________________ **Birth date** ________________ **Age** __________

Marital Status ______________ **Are you? Male Female**

Employer ______________________ **Address** ______________________________

Spouses Name ______________________________ **Birth date** ________________

Phone (____) ____________ **Employer** ________________

Emergency Contact ______________________________ **Phone (____)** ______________

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method in order to obtain this goal. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. **Health** is a state of <u>optimal function</u> physically, mentally, socially and emotionally, not merely the absence of symptoms or disease. **Vertebral Subluxation** is a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

My signature below certifies that I have read and fully understand the above statements and I therefore accept chiropractic care on this basis.

X-ray Release

X-ray Confirmation: This certifies that any concerns regarding radiation have been explained to my satisfaction. I have informed the doctor if I am currently pregnant or breastfeeding. I understand that X-rays will only be recommended to me if the doctor deems them clinically necessary. If they are recommended, I grant my permission for this procedure. In doing so, I release the Doctor from responsibility of potential damage arising there from.

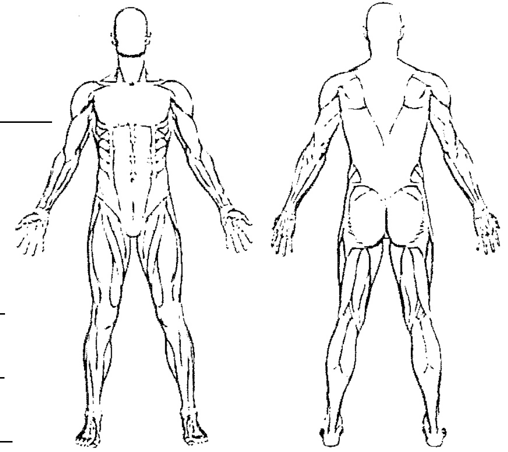
Signature: ______________________________ **Date** ______________________

Consent to treat minor Child: I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Signature of parent/ legal guardian: ______________________________ **Date** ______________________

Patient Condition ~ Name_____________________________

If you are already experiencing a symptom(s), please mark an (X) on the picture to the right where you are having them and explain below:



1st Complaint____**How long?**_________________

Have you ever experienced this symptom before? Y N

Please describe any activities that may be causing your complaint_________________________

____

Rate the severity of your pain on a scale of 1 (mild pain) to 10 (severe pain)_________________

How often do you feel this pain?____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Tightness
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: __________________________________

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

2nd Complaint____ **How long?**_________________ **Have you had this before? Y N**

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)_______________

How often do you feel this pain?____

Please describe any activities that may be causing your complaint____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Tightness
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: __________________________________

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Back Pain	☐ Bowel/Bladder issues
☐ Buzzing/Ringing in ears	☐ Bronchitis	☐ Cancer	☐ Constipation	☐ Depression
☐ Diabetes	☐ Digestive issues	☐ Dizziness	☐ Fatigue	☐ Fainting
☐ Fertility problems	☐ Fever	☐ Fractures	☐ Herniated disk	☐ Headache
☐ Hernia	☐ Hot flashes	☐ High blood pressure	☐ Irritability	☐ Jaw Problems
☐ Kidney Disease	☐ Loss of Balance	☐ Loss of smell/taste	☐ Light sensitivity	☐ Miscarriage
☐ Menstrual pain	☐ Menstrual irregularity	☐ Mood Swings	☐ Neck Pain	☐ Neck stiffness
☐ Nervousness	☐ Numbness	☐ Pins & Needles	☐ Seizures	☐ Shoulder Pain
☐ Sinus problems	☐ Stomach Upset	☐ Stroke	☐ Thyroid problem	☐ Ulcers

☐ Other ____

What treatments have you received for your condition(s)? (please circle all that apply)

Medications Surgery Physical therapy Chiropractic Massage None Other______________

Please list any doctors consulted for current condition(s):
Dr._____________________________________**Address**____
Dr._____________________________________**Address**____

Health History

How are these symptoms interfering with your life? (Check where appropriate)

	No effect	Mild Effect	Moderate Effect	Severe Effect
Work:	☐	☐	☐	☐
Exercise:	☐	☐	☐	☐
Recreation:	☐	☐	☐	☐
Relationships:	☐	☐	☐	☐
Sleep:	☐	☐	☐	☐
Self-care:	☐	☐	☐	☐
Energy:	☐	☐	☐	☐
Attitude:	☐	☐	☐	☐
Patience:	☐	☐	☐	☐
Productivity:	☐	☐	☐	☐
Creativity:	☐	☐	☐	☐
Other: ____________	☐	☐	☐	☐

List any medications you are currently taking ____

Have you had recent x-rays? **YES** **NO** **When?** ____________________ **Where?** ______________________________

Are you pregnant? **YES** **NO** **If yes, due date?** ________________ **Number of Previous births** __________________

Have you ever?

Broken bones	**YES**	**NO**	**When** __________________________	**Explain** ________________________________
Been hospitalized	**YES**	**NO**	**When** __________________________	**Explain** ________________________________
Had an auto accident	**YES**	**NO**	**When** __________________________	**Explain** ________________________________
Had a head injury	**YES**	**NO**	**When** __________________________	**Explain** ________________________________
Had a stroke	**YES**	**NO**	**When** __________________________	**Explain** ________________________________

EXERCISE:	**WORK ACTIVITY:**	**STRESS LEVELS:**
☐ **None**	☐ **Desk job**	☐ **Low**
☐ **Light**	☐ **Standing**	☐ **Moderate**
☐ **Moderate**	☐ **Light Labor**	☐ **High**
☐ **Daily**	☐ **Heavy Labor**	

On a scale of 1 to 10, how committed are you to correcting this/these problem(s)? __________

Have you previously had chiropractic care? **YES** **NO** **If yes, when** ______________ **Did it help?** ________________

What number on the scale do you think represents your health today? _____ **In which direction is it headed?** __________

What are your health goals?

Immediate ____

Short ____

Long ____

The Chiropractor at Castlebury Financial Agreement

Dear Patient:

The Chiropractor at Castlebury will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to The Chiropractor at Castlebury.

We wish to make it very clear that your health is your sole responsibility.

These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended.

I choose the following method of payment for my care at The Chiropractor at Castlebury:

_____ **CASH** - Payment is due at the time of services.

_____ **MEDICARE -** Payment is due at time of service. The Chiropractor at Castlebury will bill Medicare if requested.

_____ **INSURANCE POLICY COVERAGE** - Although I am totally responsible for charges I may incur at The Chiropractor at Castlebury, I will initially pay for my yearly deductible and the percentage agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.

I certify I have insurance with ______________________________________ and assign directly to The Chiropractor at Castlebury all insurance benefits otherwise payable to me for services rendered. I understand I am personally financially responsible for all services rendered by The Chiropractor at Castlebury whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Chiropractor at Castlebury may use my health information and may release such information to any insurance company, adjustor or attorney and their agents for the purpose of obtaining payment for services rendered by The Chiropractor at Castlebury, and I hereby release The Chiropractor at Castlebury of any consequence thereof.

My signature below also certifies I have been given the opportunity to receive a copy of The Chiropractor at Castlebury's HIPPA Privacy Practices and accept its terms.

PATIENT'S NAME: (please print)____

SIGNED:_____________________________________ Date ________/__________/________

THE
CHIROPRACTOR
@ Castlebury
Natural Healthcare Solutions

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: _______________

Witness: ____ 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 involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: ______________________________ Signature: ________________________________ Date: ________________

Parent or Guardian: __________________________ Signature: ________________________________ Date: ________________

IN ADDITION **PLEASE SIGN** THE **ARBITRATION AGREEMENT** PROVIDED

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