

A Touch of Health Chiropractic & Acupuncture Clinic

PATIENT INFORMATION

Patient Full Name: _____ (Legal)

Prefer to be called: _____

Birth Date: ____/____/____ Age: ____ Gender: F / M

Social Security Number: _____

Email Address _____ **(checked frequently)**

Marital Status: Married Separated Widowed Single

Name of Spouse _____

Spouse's Date of Birth ____/____/____

CURRENT ADDRESS AND PHONE

Street _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

INSURANCE

Insurance Carrier _____

Primary Insured Name _____

Insured Birth Date ____/____/____

Is patient covered by additional insurance? YES NO

If YES, Secondary Insurance _____

Primary Insures Name (Secondary) _____

EMPLOYMENT

Employer _____

Occupation _____

Employer Address _____

Employer City, State, Zip code _____

Who should we contact in the event of an emergency? _____

Phone (____) _____

Who can we thank for referring you? _____

I have been offered a copy of A Touch of Health Chiropractic

NOTICE OF PRIVACY PRACTICES

Signature _____ Date _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date: _____

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax) Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administration staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Printed Name: _____

Patient Signature: _____ Date: _____

(Or Patient Representative)

A Touch of Health Chiropractic Clinic

925 West Highway 92

Kearney, MO 64060

Cupping therapy may be used and complements trigger point release. Suction cups are placed at various points over the muscles, creating a vacuum, which can pull up on the skin and increases circulation and pulls toxins to the surface.

Cupping naturally draws blood to the external capillaries of the body and as a result bruises may be left after treatment.

_____ Initials

I have read and understand that I may have some bruises or reddening of the skin after a cupping treatment.

Patient Name: _____

Signature: _____

Date: _____

Insurance/Medicare Authorization 2018

A Touch of Health Chiropractic Clinic LLC

925 W Highway 92

Kearney, MO 64060

Signature on File

Please **READ AND INITIAL** each line:

____ I authorize use of this form on all my insurance transmissions

____ I authorize release of information to all my insurance carriers

____ I understand that I am responsible for my bill. **(CASH&INS PATIENTS)**

____ I authorize my doctor to act as my agent in obtaining payment from my insurance carrier

____ I authorize payment direct to my doctor

____ I permit a copy of this authorization to be used in place of the original **(CASH&INS PATIENTS)**

Name: _____

Signature _____ Date: _____

I give A Touch of Health Chiropractic Clinic permission to email my statement. If you wish to opt out of this, please cross through this page.

Printed Name: _____

Signature: _____

Email Address: _____

Date: _____

Present Complaints

Patient: _____

Reason for your visit

When did symptoms begin: _____

Is this condition getting progressively worse? YES NO

Is the pain constant or does it come and go? _____

Circle type of pain

Sharp Dull Throbbing Numb Achy Shooting Burning Tingling Cramps Stiff

How often do you have this pain? _____

What makes it better? _____

What makes it worse? _____

When, during the day, is it worse? _____

- Does it interfere with your: ___ work
- ___ sleep
- ___ daily routine
- ___ recreation

List other doctors seen for this condition:

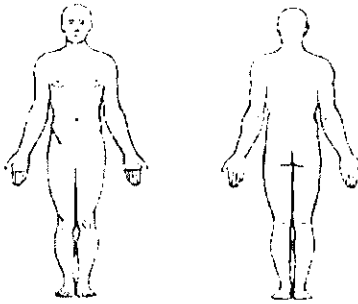
Please mark on the following scale your level of pain.

If more than one symptom, please indicate a level of pain for each:

No discomfort.....Worst possible

0 1 2 3 4 5 6 7 8 9 10

Mark with an X where you have pain, numbness, or tingling: ----->



Health Questionnaire

Please check mark each of the conditions below that YOU are currently experiencing

Patient: _____ Date: _____

- | | | | |
|---|--|--|---|
| <u>Musculo Skeletal System</u> | <u>Genito-Urinary System</u> | <u>Gastro-Intestinal System</u> | <u>Eye, Ear, Nose and Throat</u> |
| <ul style="list-style-type: none"> <input type="checkbox"/> Low back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm problems <input type="checkbox"/> Leg problems <input type="checkbox"/> Swollen joints <input type="checkbox"/> Painful joints <input type="checkbox"/> Stiff joints <input type="checkbox"/> Sore muscles <input type="checkbox"/> Weak muscles <input type="checkbox"/> Walking problems <input type="checkbox"/> Spasms <input type="checkbox"/> Broken bones <input type="checkbox"/> Shoulder pain | <ul style="list-style-type: none"> <input type="checkbox"/> Bladder trouble <input type="checkbox"/> Excessive urination <input type="checkbox"/> Scanty urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Discolored urine <li style="text-align: center;"><u>Female</u> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Breast pain <input type="checkbox"/> Lumps on the breast | <ul style="list-style-type: none"> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Difficult chewing <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Weight trouble | <ul style="list-style-type: none"> <input type="checkbox"/> Eye strain <input type="checkbox"/> Eye inflammation <input type="checkbox"/> Vision problems <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose pain <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nose discharge <input type="checkbox"/> Difficult breathing through nose <input type="checkbox"/> Sore gums <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficult speech <input type="checkbox"/> Sinus <input type="checkbox"/> Allergy <input type="checkbox"/> Jaw pain |
| <u>Cardio-Vascular Respiratory</u> | <u>Nervous System</u> | <u>Habits</u> | |
| <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Pain over heart <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing phlegm <input type="checkbox"/> Coughing blood <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Lung problems <input type="checkbox"/> Varicose veins | <ul style="list-style-type: none"> <input type="checkbox"/> Numbness <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Muscle jerking <input type="checkbox"/> Convulsions <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia | <ul style="list-style-type: none"> <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Coffee or Tea <input type="checkbox"/> Exercise <input type="checkbox"/> Drug abuse <input type="checkbox"/> _____ | |

ARE YOU PREGNANT?
YES NO

Patient's Signature: _____

~~~~~**DO NOT WRITE BELOW THIS LINE**~~~~~

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Patient accepted?    YES    NO    Doctor's Signature \_\_\_\_\_



# Health History

|                                                                                   |                               |                  |                  |
|-----------------------------------------------------------------------------------|-------------------------------|------------------|------------------|
| What treatment have you already received for your condition?                      | Medications                   | Surgery          | Physical Therapy |
| Chiropractic Services                                                             | None                          | Other            |                  |
| Name and address of other doctor(s) who have treated you for your condition _____ |                               |                  |                  |
| Date of last: Physical Exam _____                                                 | Spinal X-Ray _____            | Blood Test _____ |                  |
| Spinal Exam _____                                                                 | Chest X-Ray _____             | Urine Test _____ |                  |
| Dental X-Ray _____                                                                | MRI, CT-Scan, Bone Scan _____ |                  |                  |

Place a circle "YES" or "NO" to indicate if you have had any of the following:

|                     |     |    |                  |     |    |                     |     |    |                          |     |    |
|---------------------|-----|----|------------------|-----|----|---------------------|-----|----|--------------------------|-----|----|
| AIDS/HIV            | YES | NO | Chicken Pox      | YES | NO | Liver Disease       | YES | NO | Rheumatoid Arthritis     | YES | NO |
| Alcoholism          | YES | NO | Diabetes         | YES | NO | Measles             | YES | NO | Rheumatic Fever          | YES | NO |
| Allergy Shots       | YES | NO | Emphysema        | YES | NO | Migraine            | YES | NO | Scarlet Fever            | YES | NO |
| Anemia              | YES | NO | Epilepsy         | YES | NO | Headaches           |     |    | Stroke                   | YES | NO |
| Anorexia            | YES | NO | Fractures        | YES | NO | Miscarriage         | YES | NO | Suicide Attempt          | YES | NO |
| Appendicitis        | YES | NO | Glaucoma         | YES | NO | Mononucleosis       | YES | NO | Thyroid Problems         | YES | NO |
| Arthritis           | YES | NO | Goiter           | YES | NO | Multiple Sclerosis  | YES | NO | Tonsillitis              | YES | NO |
| Asthma              | YES | NO | Gonorrhea        | YES | NO | Mumps               | YES | NO | Tuberculosis             | YES | NO |
| Bleeding Disorders  | YES | NO | Gout             | YES | NO | Osteoporosis        | YES | NO | Tumors, Growth           | YES | NO |
| Breast lump         | YES | NO | Heart Disease    | YES | NO | Pacemaker           | YES | NO | Typhoid Fever            | YES | NO |
| Bronchitis          | YES | NO | Hepatitis        | YES | NO | Parkinson's Disease | YES | NO | Ulcers                   | YES | NO |
| Bulimia             | YES | NO | Hernia           | YES | NO | Pinched Nerve       | YES | NO | Vaginal Infections       | YES | NO |
| Cancer              | YES | NO | Herniated Disk   | YES | NO | Pneumonia           | YES | NO | Venereal Disease         | YES | NO |
| Cataracts           | YES | NO | Herpes           | YES | NO | Polio               | YES | NO | Whooping Cough           | YES | NO |
| Chemical Dependency | YES | NO | High Cholesterol | YES | NO | Prostate Problem    | YES | NO | OTHER _____              |     |    |
|                     |     |    | Kidney Disease   | YES | NO | Prosthesis          | YES | NO | ARE YOU PREGNANT? YES NO |     |    |
|                     |     |    |                  |     |    | Psychiatric Care    | YES | NO | DUE DATE _____           |     |    |

|                        |                      |
|------------------------|----------------------|
| <u>Exercise</u>        | <u>Work Activity</u> |
| None                   | Sitting              |
| Moderate               | Standing             |
| Daily                  | Light Labor          |
| Heavy                  | Heavy Labor          |
| <u>Habits</u>          |                      |
| Smoking                | Packs/Day _____      |
| Alcohol Drinks/Day     | _____                |
| Coffee/Caffeine drinks | Cups/day _____       |
| High Stress Level      | Reason _____         |

| Injuries/Surgeries | Description | Date  |
|--------------------|-------------|-------|
| Falls              | _____       | _____ |
| Head Injuries      | _____       | _____ |
| Broken Bones       | _____       | _____ |
| Dislocations       | _____       | _____ |
| Surgeries          | _____       | _____ |
| Auto Accidents     | _____       | _____ |

|                               |
|-------------------------------|
| Medications _____             |
| Pharmacy Name _____           |
| Pharmacy Phone ( ) _____      |
| Allergies _____               |
| Vitamins/Herbs/Minerals _____ |

# Functional Rating Index

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your Neck and/or Back Problems have affected your ability to manage everyday activities. For each item below, please circle the number which closely describes your condition right now.

- |                            |         |   |   |   |   |   |   |   |    |              |
|----------------------------|---------|---|---|---|---|---|---|---|----|--------------|
| 1. Pain Intensity          | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 2. Sleeping <sup>1</sup>   | 2       | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |              |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 3. Personal care           | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 4. Travel                  | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 5. Work                    | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 6. Recreation <sup>1</sup> | 2       | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |              |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 7. Frequency               | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 8. Lifting                 | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 9. Walking                 | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |
| 10. Standing               | 1       | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9  | 10           |
|                            | No Pain |   |   |   |   |   |   |   |    | Extreme Pain |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_