

PATIENT HISTORY

Previous Auto Accidents or Trauma?

Description

Date

Falls: _____

Head Injuries: _____

Fractures: _____

Broken Bones: _____

Dislocations: _____

Recent or Major

Surgeries: _____

Have you been diagnosed or been told you have any of the following? (please check and/or circle all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia or other blood/lymph related condition |
| <input type="checkbox"/> Heart condition/Cardiovascular Condition | <input type="checkbox"/> Herniated disk/Spinal Condition |
| <input type="checkbox"/> Skin / Breast Condition | <input type="checkbox"/> Hypertension or Stroke (please circle) |
| <input type="checkbox"/> Osteoporosis/Bone spurs/Bone Condition | <input type="checkbox"/> Depression or Psychiatric Condition (please circle) |
| <input type="checkbox"/> Hardening of arteries/Vascular Condition | <input type="checkbox"/> Brain or spinal cord - Neurological Condition |
| <input type="checkbox"/> Lung/Respiratory Condition | <input type="checkbox"/> Blurred vision/Double vision/Eye Condition |
| <input type="checkbox"/> Blood in stool – Gastrointestinal Condition | <input type="checkbox"/> Condition w/ Ears/Nose/Mouth/Throat |
| <input type="checkbox"/> Blood in urine–Genital/Urinary Condition | <input type="checkbox"/> Diabetes or Endocrine Condition Other _____ |

Have you had any of the following symptoms during the past year? (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Dizziness / Ringing in ears / Hearing loss | <input type="checkbox"/> Temporary lack of understanding |
| <input type="checkbox"/> Loss of bowel/bladder control | <input type="checkbox"/> Numbness or loss of sensation in the face, arms, hands, fingers or legs |
| <input type="checkbox"/> Night Pain / Severe Night Sweats | <input type="checkbox"/> Any other abnormal or loss of sensation in another body part |
| <input type="checkbox"/> Prolonged use of corticosteroids | <input type="checkbox"/> Weakness, clumsiness, or strength loss in the face, arms, hands, fingers or legs |
| <input type="checkbox"/> Abdominal pain/pulsations | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of consciousness / Sudden collapse w/out loss of consciousness |
| <input type="checkbox"/> Slurred speech or other speech problems | <input type="checkbox"/> Numbness across the buttocks and groin region |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diminished or partial loss of vision | |

Have you had any of the following childhood diseases:

- Measles
- Rubella
- Chickenpox
- Mumps
- Scarlet Fever
- Rheumatic Fever
- Tuberculosis
- Other _____

Do any diseases run in your family?

Please list any allergies:

Are you under a doctor's care presently for any type of health problem? **Yes No** (please circle)

If yes, please explain:

Have you ever suffered a stroke?

Yes

No

Have any relatives ever suffered a stroke?

Yes

No

Women

Do you take birth control pills? **Yes No**

How long? _____

Do you experience any of the following symptoms: (please circle)

Menstrual pain Cramping Irregularity

Date of last period: _____

Are you pregnant? **Yes No** Due Date: _____

MEN

Date of last prostate exam: _____

Difficulty with urination? **Yes No**

Excessive urination? **Yes No**

CANCELLATIONS AND NO-SHOWS

Cancellations - Our office policy requires a 24 hour notice for appointment cancellations or rescheduling. We typically have a waiting list of patients who would like to see the doctor. If you cannot make your appointment, please extend the office and other patients the courtesy of giving ample notice so that someone on the waiting list may be seen during that time.

No-Shows - We understand that things do come up and we will try to be as accommodating as possible. But please be aware that a \$25 fee will be assessed for no-shows and cancellations without a 24 hour notice.

**CONSENT FOR USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS (HIPPA)**

I consent to the use or disclosure of my protected health information (PHI) by **Sports & Family Chiropractic & Acupuncture** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Joshua Kilpatrick DC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Sports & Family Chiropractic & Acupuncture** is not required to agree to the restrictions that I may request. However, if **Sports & Family Chiropractic & Acupuncture** agrees to a restriction that I request, the restriction is binding on **Sports & Family Chiropractic & Acupuncture**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Sports & Family Chiropractic & Acupuncture** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Sports & Family Chiropractic & Acupuncture** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices for **Sports & Family Chiropractic & Acupuncture** is located in the reception office. This Notice of Privacy Practices also describes my rights and **Sports & Family Chiropractic & Acupuncture** duties with respect to my protected health information. **Sports & Family Chiropractic & Acupuncture** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature

Printed Name

Date

Consent To Treatment

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other procedures to be used so that you can make the decision whether or not to undergo the procedures after knowing potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedures.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various diagnostic tests, acupuncture or other related remedies on me (or the patient named below that I am legally responsible for) by Dr. Josh Kilpatrick, the Doctor of Chiropractic, and/or those working at the office who now or in the future treat me while employed by, working for or associated with, or serving as a backup doctor for the Doctor of Chiropractic.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, or other clinic personnel, my diagnosis, the nature and purpose of chiropractic adjustments and the plan of treatment or other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks and hazards to examination and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I understand that neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the Doctor at the time; and that I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above Consent. I have also had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this Consent Form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the Patient:

To be completed by the Doctor/ Staff:

Print Name

Witness to Patient's Signature

Signature of Patient or Legal Guardian

Date Signed

Date Signed