Meyer Clinic of Chiropractic WELCOME

PERSONAL INFORMATION

****PLEASE FILL OUT FRONT & BACK OF BOTH PAGES****

First Name:_____**M.I**._____**Last Name**:_____**Preferred Name**:_____

Address:_____**City**:_____**State:**_____**Zip:**_____

Birthdate:_____/_____/_____**Age**_____**Gender**: □ Male □ Female □ Unspecified **SSN**:_____/_____/_____

Primary Phone:_____**Cell Phone**:_____**Work Phone**:_____

Home Email:_____**Work Email**:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (*check one*) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Status: (check one) □Single □Married □Divorced □Widowed □Separated **Children?** Yes No **How Many?**_____

Spouse Name:_____

Race: □White □Black/African American □Hispanic □Asian □Native American

Ethnicity: □ Hispanic or Latino □Not Hispanic of Latino □ I choose not to specify

Preferred Language: □English □Spanish □ French □Vietnamese □ Chinese □German □Other_____

Do you require a translator? _____

Occupation:_____Employer: _____

Name of Family Physician: _____

How were you referred to Meyer Clinic of Chiropractic: □Patient_____ □Physician _____

□Yellow Pages □ Internet □Sign □Other _____

Emergency Contact: (Name, Relationship, Phone#)_____

Verification Question: (*Choose only 1 question by checking the question, then provide answer to the question*) □ What is the name of my favorite pet? □ In what city was I born? □What high school did I attend? □What is the make of my first car?

Verification answer_____Must be at least 6 characters.

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

Primary Insurance Carrier:_____Phone:_____

Policy#_____Group #_____Claim#_____

Name of Policy Holder:_____Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____Policy Holder's SSN:_____/____/_____Employer:_____

Is patient covered by another insurance? □ Yes □ No **Secondary Insurance Carrier**:_____Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Meyer Clinic of Chiropractic of Dubuque Ia, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

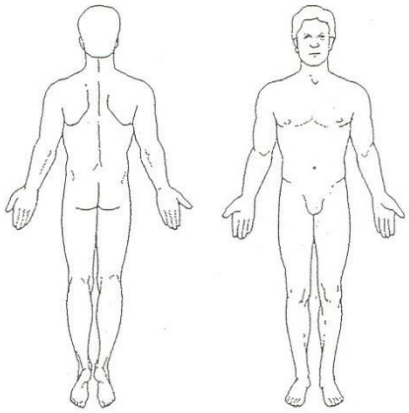
What caused this complaint(s)?_____

_____

When did this complaint begin?_____/_____/_____**Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? ***Circle all*** *that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain					***Moderate Pain***					***Worst Possible Pain***
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

What area(s) does the pain radiate, shoot or travel to? (*if applicable*)

_____

What aggravates this complaint? *Circle all that apply*: Sitting / Standing / Walking / Getting up from seated / Walking stairs / Inactivity / Sleeping / physical activity / exercise / movement / bending forward / bending backwards / twisting / reaching / lifting / desk work / sneezing / coughing / everything / unknown / Other: _____

What relieves this complaint? *Circle all that apply*: Sitting / standing / walking / resting / exercise / movement / stretching / massage / chiropractic / heat / ice / laying down / medication / nothing / unknown / Other: _____

How often do you experience your symptoms? □25% of the day □50% of the day □75% of the day □100% of the day

Timing of complaint: □ Morning □As day progresses □Afternoon □Evening □ Sleeping □during activities □after activities □symptoms are constant and do not change. Other:_____

Over time, are your symptoms: □ Improving □ Worsening □Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes" please provide the following information:

Dr. Name:_____Date consulted: _____

Diagnosis: _____

Is this condition interfering with your: *Circle all that apply* Sleep / getting in or out of a chair or bed / personal care / travel / work / recreation / lifting / walking / standing / daily routine / social activities / exercise routine / Other: _____

Is your complaint interfering with your daily activities: □ Not at all □ A little bit □ Moderately □Quite a bit □Extremely

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

WOMEN ONLY: **Currently pregnant? □Yes □No If yes, date of last period**_____ **Miscarriage? □Yes □No**

Do you have children? Yes no Type of birth *(circle one)* **Vaginal or C-Section. Painful/Abnormal Menstrual Cycle □Yes □No**

Menopause: □yes □ no

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?:

Do you currently smoke tobacco or cigarettes of any kind? □ Yes □ Former smoker □ Never been a smoker

If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓:**

If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

Do you drink alcohol? □Yes □No How many drinks per week? For how many years?

Do you drink caffeine? □Yes □No How many drinks per day? What type? □ Coffee □Tea □Soft drinks □Energy drinks

Do you take pain killers? □Yes □No How often? □Daily □weekly □monthly □rarely What type Aspirin Ibuprofen Tylenol **What do you're your duties include?** □Sitting □ standing □light labor □heavy labor other: _____

Please describe your overall health right now? □ Excellent □very good □good □fair □ poor

What is your current stress level □Mild □ moderate □ high

Have you ever seen a chiropractor in the past? □ Yes □ no

What are your hobbies? _____

X NAME:_____ DATE:_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click, " much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Meyer Clinic of Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Meyer Clinic of Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient's Name (Please print) Doctor's Name (Please print)

X_____ _____

Signature of Patient, Parent or Legal Guardian (if a minor) Doctor's Signature

REV12/14

Meyer Clinic of Chiropractic HIPPA Policy

By signing below you are acknowledging Meyer Clinic of Chiropractic has giving you access to the policy and you understand your rights as a patient and our responsibilities as a provider.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice:

Notice effective date is June 1, 2016

- ***Steffany Walker, Compliance Officer. Email address: steffany@dubuquechiropractor.com***
- ***We will never market or sell your information to anyone.***
- ***We will never share any substance abuse treatment records without your written permission.***

Meyer Clinic of Chiropractic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Please initial ONE option below and sign & date at the bottom of page:

_____ I have received the Meyer Clinic of Chiropractic Privacy Policies.

_____ I have been offered the Meyer Clinic of Chiropractic Privacy Policies but declined to take copy.

_____ I would like to receive the digital version of the Meyer Clinic of Chiropractic Privacy Policy.

Signed: _____ Date: _____