Blue Hills Chiropractic New Patient Form 12-17 Years Old

морс нуŘ !ǾŜΦΣ /ǳϒōŜǊfl·yŘ
тмрΦуннΦнрлл

11 E Marshall St., Rice Lake
715.475.1700

Name: ______________________ Date: ____________ Referred By: ______________
Address: ______________________ City: ____________ State: ________ Zip code: ____________
Home Phone: ______________ Cell Phone: ______________ Email: ______________
Date of Birth: ____________ Age: ________ Gender: __________ Social Security: ______________
Parents' Names: ______________ Mom cell: ______________ Dad cell: ______________
Employer (if applicable): ______________________
Primary Care Physician: ______________________ Clinic Name: ______________

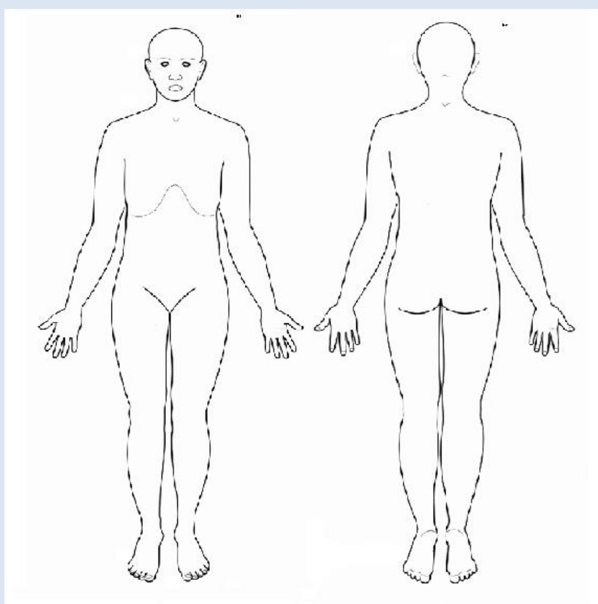
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care here? Y N
Primary Insurance: ______________________ Secondary Insurance: ______________
Policy Holder's Name: ______________________ Policy Holder's Birth Date: ______________

History of Present Illness

Is your visit for wellness care? Y N
Chief Complaint: ____
Date symptoms began: ____________ Due to: Auto Work Other: ______________________
Have you experienced similar symptoms before? Y N If yes, when? ______________

Indicate where & type of pain

Ache >>>>
Numb ====
Pins & Needles ooo
Burn XXX
Stabbing ////
Throbbing ~~~
Radiating Pain, use arrows



DOCTOR USE ONLY

Setting: AM
MIDDAY
PM

Progression: WORSE
BETTER
SAME

CONSTANT ____________
COME & GO ____________

Please Rate your current pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

What makes this pain worse: ______________________ What makes this pain better ______________

Have you seen any other health care providers for this complaint? Y N If yes, who: ______________
Results: ______________________ Were X-Rays or other imaging taken? ______________
Please check any of the following activities which the pain affects:

______Lying on back	______Gripping	______Pushing	______Bending forward
______Lying on side	______Reaching	______Kneeling	______Standing for >1hr
______Turning over in bed	______Climbing stairs	______Sleeping	______Cough/Sneeze/Grunt
______Getting in/out of car	______Dressing Self	______Sitting	______Walking

Past Medical History

Please list all injuries, major illnesses, surgeries, falls, auto accidents, or hospitalizations

Injury/Illness	Date	Treatment	Residual Symptoms
1.			
2.			
3.			
4.			
5.			

Have you ever had chiropractic care? Y N When?_____ If yes, who did you see?_____

What were the results? _____

Please check each of the conditions you have currently, or have had in the past:

_____Blurred Vision
_____Light sensitivity
_____Ringing of ears
_____Congested Sinus
_____Headaches
_____Loss of balance
_____Fainting
_____Neck pain
_____Thyroid
_____Difficulty Breathing
_____Chest pain
_____High Blood Pressure
_____Pacemaker
_____Stroke
_____Cancer

_____Low Back pain
_____Shoulder/Arm pain
_____Pain between shoulders
_____Arthritic pain
_____Ulcers/Colitis
_____Allergies
_____Asthma
_____Numbness
_____Digestive problems
_____Heartburn/Indigestion
_____Loss of sleep
_____Knee/Foot pain
_____Swelling
_____Diabetes
_____Epilepsy

_____Loss of Appetite
_____Unexplained weight loss
_____Excessive thirst
_____Irregular Menstrual flow
_____Hot flashes
_____Breast soreness/lumps
_____Loss of bladder control
_____Frequent urination
_____Painful urination
_____Constipation
_____Dermatitis/Eczema/Rash
_____Depression
_____Blood disorder
_____Bladder Infection
_____Gallbladder/Kidney Problems

Please list any current medications or supplements: _____

_____

Please circle if you have a family history of:

Cancer Heart Disease Diabetes Stroke Epilepsy Migraines Back pain

Social Health History

How many hours a week do you spend sitting?_____ Are you happy? Y N Hours of sleep per night:_____

Do you exercise? Y N How often?_____ Type of exercise: _____

Do you drink caffeine? Y N Amount per week:_____ Do you drink Alcohol? Y N Amount per week: _____

Do you use tobacco? Y N #___per: day week (circle one) How much water do you drink per day?_____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my child's condition as she deems appropriate through the use of chiropractic care.

Guardian Signature: _____ Date:_____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.
Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June, 1993) Estimate that incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort. Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment testing and evaluation are performed carefully to minimize risk. Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered on my child.

Printed Name: _____

Guardian Signature: _____ **Date:** _____

Authorization & Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

May we send you mail that may allow others to see that you are a patient of Blue Hills Chiropractic, such as appointment reminder postcards, or invitations to special events? Y N (circle one) Initials: _____

When we call, may we leave information about current appointments you have with Blue Hills Chiropractic on your voicemail or answering machine? Y N (circle one) Initials: _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

-You may request restrictions on your disclosures.
-You may inspect and receive copies of your records within 30 days with a request
-You may request to view changes to your records
-In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
-Obtain payment from third party payers
-Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand the Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request in writing, that you restrict how my personal information is used and or disclosed.

Printed Patient's Name: _____

Patient/Guardian Signature: _____ Date: _____