SpineCare Patient Information

First Name:________________________________ MI: ______ Last Name:_____________________________

Home Address: ____
(city) (State) (Zip)

Home Phone: (_____)________ Cell Phone: (______)________ Email: _________________________________

Marital Status: S / M / D / W Sex: Male / Female Date of Birth: ____/______/_____________

Name Of Spouse: __________________________________Spouses DOB: ______________________________

Patient Employer: (______)_______________________ Employer Phone: (______)_______________________

Emergency Contact: (____)___________ Phone: (____)_________ Relationship to patient:_________________

Whom may we thank for referring you? ____

Accident Information

Only select "yes" for auto/ work if there is an open case pertaining to injury.

Is this due to an accident? ☐ Yes ☐ No If yes, what is the Date of accident: _____/_____/_________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other: ___________________________________

If yes, to whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other: ___________________________________

Attorney name (if applicable):____

Insurance Information

Primary Insurance:______________________________ Secondary Insurance:____________________________

Policy Holders Name: ____ Policy holders DOB: ____/_____/____

Policy Holders Address:____

Assignment and Release

I certify that I, and/ or my dependant(s) have insurance coverage with ____________________________________(Name of Insurance company) and assign directly to the SpineCare LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor 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 insurance benefits payable for related services.

____ ____
Signature of Patient, Parent, Guardian, Or Personal Representative *Print Name of Patient, Guardian or Rep,*

______________________ ____
Date *Relationship to Patient (For Guardian or Personal Representative)*

SpineCare Chiropractic Case History Form

Patient Name:_______________________________________ **Date:** __________________ **ID#**______________

1. **Symptom 1:**____

2. **When did the symptom begin?** ____

3. **Did the symptom begin ☐ suddenly or ☐ gradually? (check one)**

4. **How did the symptom begin?** ____

5. **What percentage of the time you are awake do you experience the above symptom? (check one)**

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐95 ☐100

6. **Describe the quality of the symptom (check all that apply)**

☐ Dull ☐ Ache ☐ Burning ☐ Stabbing/Sharp ☐ Stiff ☐ Numbness ☐ Pins & Needles ☐ Other: _____________

7. **On a scale of 0-10 with, 10 being the worst, please circle the number that best describes the symptom most of the time: (check one)**
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

8. **Does the symptom radiate to another part of your body?** ☐ Yes ☐ No
   If yes, where does the symptom radiate to____

9. **What makes the symptom better? (check all that apply)**

☐Nothing ☐Resting ☐Ice ☐Heat ☐Stretching ☐Exercise ☐Walking ☐Pain Medication ☐Muscle Relaxer

☐Chiropractic Adjustments ☐Massage ☐ Other:(please describe) ______________________________________

10. **What makes the symptom worse? (check all that apply)**

☐Nothing ☐Any movement ☐Lifting ☐Sitting ☐Getting up from seated position ☐Chewing ☐Changing positions

☐ Lying Down ☐ Reading ☐Working ☐Exercising Laying on side in bed ☐Other:_________________________

11. **Is the symptom worse at a certain time of the day or night? (check all that apply)**

☐ Unchanged ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Other: __________________________

12. **Have you had this type of pain in this location before?** ☐ Yes ☐ No

13. **Have you had treatment for this condition and episode prior to today's visit?**
    - ☐ No
    - ☐ Anti-Inflammatory Medication (e.g., ibuprofen, advil, aspirin etc.)
    - ☐ Pain Medication
    - ☐ Muscle Relaxers
    - ☐ Trigger Point Injections
    - ☐ Cortisone Injection
    - ☐ Surgery
    - ☐ Massage
    - ☐ Physical Therapy
    - ☐ Chiropractic
    - ☐ Other (please describe): ____

SpineCare Health History Form

Name:____ Date: _________________________________

Habits

Do you smoke or chew tobacco? ☐ Yes ☐ No

How much coffee/ tea do you typically consume a day? ☐ None ☐ 1-2 cups ☐ 3-7 Cups ☐ 8+

How much soda/pop do you typically consume a day? ☐ None ☐ 1-2 cups ☐ 3-7 Cups ☐ 8+

How much alcohol do you typically consume in a week ☐ None ☐ 1-2 cups ☐ 3-7 Cups ☐ 8+

Typical physical activity at work? ☐ Sitting ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

General physical activity when not working? ☐ Usually Sitting ☐ Usually Active ☐ Very Active

Outside of work do you exercise on a regular basis? ☐ Yes ☐ No

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Family Health History

How is your fathers health? ☐ Good ☐ Fair ☐ Poor ☐ Deceased ☐ Unknown

How is your mothers health? ☐ Good ☐ Fair ☐ Poor ☐ Deceased ☐ Unknown

How is your sibling health? ☐ Good ☐ Fair ☐ Poor ☐ Deceased ☐ Unknown

List any health problems that run in your family. ____

Has anyone in your immediate family ever had a stroke? ☐ Yes ☐ No

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Females Only

Were the results of your last exam/pap smear normal? ☐ Yes ☐ No ☐ Unsure Date of Exam: _______________

Age of your children: ____

Check each symptom / problem you have had in the last year:

☐ Painful Periods ☐ PMS ☐ Yeast Infection ☐Cramps or backache during cycle

☐ Excessive flow during cycle ☐ Vaginal Discharge ☐ Miscarriage ☐ Hot Flashes

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Is there a chance that you might be pregnant? ☐ Yes ☐ No

When did your last menstrual cycle begin? ____

Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have an IUD? ☐ Yes ☐ No

PREGNANCY WARNING AND CONSENT TO X-RAY

Signature only needed if female

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that if there is a chance that I might be pregnant the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination. With full understanding of the above, and believing that I am not currently at risk, I give the doctors at SpineCare LLC permission to perform an x-ray examination if they feel it is neccesary.

Patients Signature : ____ *Date:* ________________________

SpineCare Health History From

Name: ______________________________ Date: ______________

Primary Care Physician: ______________________ Date of last PCP appt: __________

Have you ever had surgery? If so, what was the procedure(s)? ________________ ☐ Yes ☐ No

Have you ever been diagnosed with a long-term or ongoing health problem? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Have you been sick at all in the last 60 days? ☐ Yes ☐ No

Have you ever had a convulsion, seizure or stroke of any kind? ☐ Yes ☐ No

Have you ever passed out, blacked out or fainted? ☐ Yes ☐ No

Have you been dizzy or light headed in the last 60 days? ☐ Yes ☐ No

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Have you had any unusual vision or hearing problems recently? ☐ Yes ☐ No

Have you had ringing in your ears in the last 60 days? ☐ Yes ☐ No

Have you had a headache in the last 60 days? ☐ Yes ☐ No

Have you ever had a heart attack or been diagnosed with a heart condition? ☐ Yes ☐ No

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Have you ever been diagnosed with high or low blood pressure? ☐ Yes ☐ No

Do you have frequent colds, sinus infections, ear infections, or sore throats? (circle all that apply) ☐ Yes ☐ No

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Do you have asthma or any allergies? Please list here: ______________________ ☐ Yes ☐ No

Males, have you ever been diagnosed with a prostate problem? ☐ Yes ☐ No

Do you have trouble controlling your urination? ☐ Yes ☐ No

Have you had frequent or painful urination in the last 60 days? ☐ Yes ☐ No

Have you had a kidney or bladder infection in the last 60 days? ☐ Yes ☐ No

Do you have a problem with recurring kidney/bladder infections? ☐ Yes ☐ No

Have you been constipated or had diarrhea in the last 60 days? ☐ Yes ☐ No

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Do you have any sores or skin lesions that are not healing? ☐ Yes ☐ No

Have you had weakness, twitching or tremors in your arms/hands or legs/feet in the last 60 days ? ☐ Yes ☐ No

Have you ever broken or dislocated a joint? ☐ Yes ☐ No

Have you ever had a motor vehicle accident or fender better? ☐ Yes ☐ No

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Have you ever had a fall or injury that required professional attention? ☐ Yes ☐ No

Have you ever been given a permanent disability rating? ☐ Yes ☐ No

Have you ever had a X-rayMRI or CT scan before? ☐ Yes ☐ No

Have you ever had chiropractic care before? ☐ Yes ☐ No

If you marked "yes" to any questions that require further explanation, please do so: ______________

____

____

Informed Consent Document

Patient Name: ____

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 Chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation 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. That may cause an audible “pop” of “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

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

☐ Spinal Manipulative Therapy	☐ Ultrasound	☐ Vital Signs
☐ Range of Motion Testing	☐ Palpation	☐ EMS
☐ Muscle Strength Testing	☐ Orthopedic Testing	☐ Basic Neurological Testing
☐ Postural Analysis	☐ 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 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 treatment. 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 estimated to occur between one in a million and one in five million cervical adjustment. The other complications are also generally described as rare.

Informed Consent Document

The availability and nature of other treatment options

Other treatment options for your condition may include:
☐ Self-administered, over the counter analgesics and rest
☐ Medical care and prescription drugs such as anti-inflammatory, muscle relaxers, and pain killers.
☐ Hospitalization
☐ 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 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 BLOCKS 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 Dr. Charles Duda/Dr. Nicolas Herrild/ Dr. Kayley Nelson and have had my questions answered to my satisfaction. 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.

Date: ________________________

____
Patients Name

____
Signature

Date: ________________________
Kayley Nelson, D.C.
Charles R. Duda, D.C
Nicolas Herrild, D.C.
Doctors Name

____
Signature

____________________________________ ***Signature of Parent or Guardian (If Minor)***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________________, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Spine Care, LLC which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

____________________ ____________________________________

Date Signature

____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO THE PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of ________________________ (patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In the effort to obtain the patient's acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (check all the apply):

☐ Personally ☐ Mail ☐ Phone Follow Up

☐ Other: ____

____________________ ____________________________________

Date Signature

____

Print Name of Physician

Spine Care, LLC

Name of Practice