Blue Ribbon Chiropractic

Name:_____

Date Symptoms Began _____

What is the current complaint? _____

Is the condition due to: □ Auto Accident □ Work injury □ Other Accident □ Illness □ Unknown

Briefly describe what you think caused your pain:_____
_____

What aggravates your condition? □Standing □Sitting □Walking □Twisting □Lying □Lifting

Are your symptoms:	List All Surgeries:	List Prescription Drugs:
□Improving	_____	_____
□About the Same	_____	_____
□Getting Worse	_____	_____
□Comes and goes	_____	_____

Chewing Tobacco: Yes or No
Smoker: Yes or No Years:_____

Allergies to Medications: _____
_____

Stress Level: □Little to None □Minimal □Moderate □Greatly Stressed
Exercise: □No Exercise Program □Light □Moderate □Strenuous
Physical Activity: □Sitting 50% or More □Light Labor □Heavy Labor □Repeated Motions

Do you have high blood pressure? Yes or No Diabetes? If YES; Type 1 or Type 2; or NO

Have you had these symptoms before? □No □Yes When? _____
Pregnant? □No □Yes Due:_____
How would you rate your eating habits?: (1 Worst- 10 Best): _____
Family History of Health Problems:

Father	
Mother	
Siblings	
Children	

Who is your Family Doctor? _____
Have you had Chiropractic Before? _____When?_____X-ray/MRI_____

How did you hear about our office? _____
Your e-mail: _____

Signature:_____ **Date:**_____

Consent to Treat a Minor: _____Relation:_____**Date:**_____

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Name_____
First Middle Last

Birthdate:_____ Age:_____ Sex: (M F)

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

Land Line: _____ Cell:_____ Work:_____

Social Security#: _____ Driver's License#:_____ State:_____

Marital Status: (M S D W) Employer:_____ Occupation:_____

Name of Insured:_____ Insurance Company:_____

Insured Date of Birth:_____

Emergency Contact Name:_____Relation:_____ Phone:_____

Ethnicity (please circle): Caucasian African American Asian Hispanic Other

NOTICE OF PRIVATE PRACTICES (HIPPA):

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

- Treatment
- Payment
- Health care Options
- Advice of Appointments and Services
- Directory/Sign-In Log
- Court Orders, Subpoenas and Government Investigations
- Advise Family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPPA compliance.

I understand by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through the HIPPA officer at this location.

Release of Information: I authorize the release of any information concerning my health and healthcare services to my insurance companies, prepaid health plan and/or Medicare/Medicaid.

Payment Agreement: I understand there is no guarantee that my insurance company(ies) or prepaid health plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature:_____ **Date**:_____

Consent to Treat a Minor:_____ **Date**:_____

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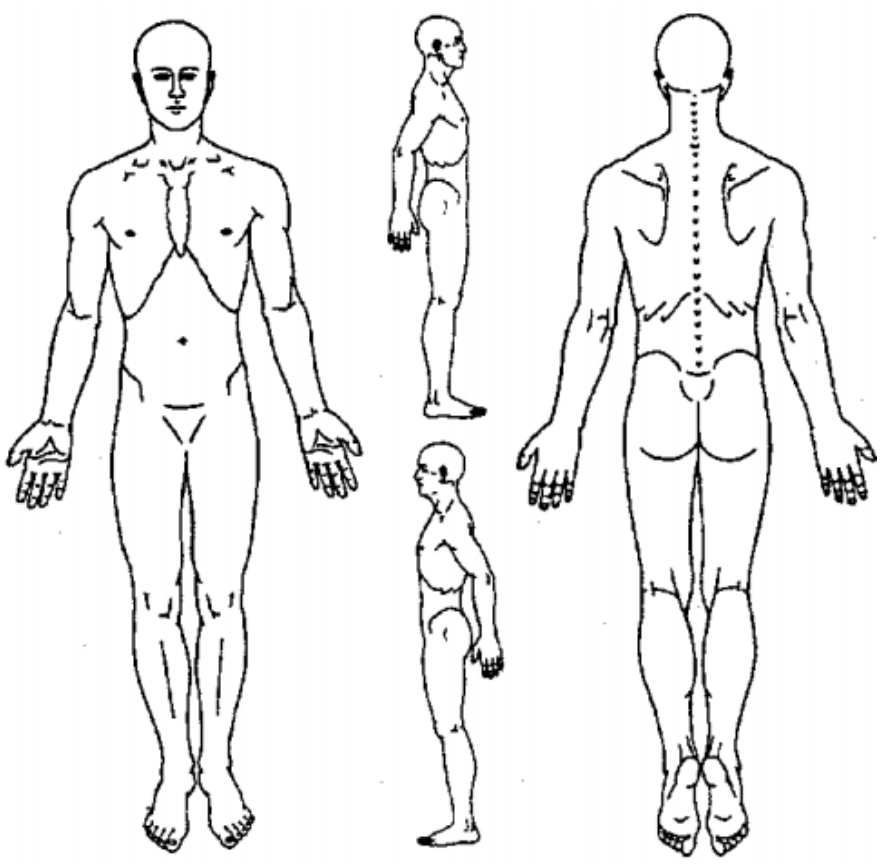
Please indicate your pain on the diagram below:



Symptom key

=====	Aching
dddd	Stiffening
^^^^	Tightness
cccc	Cramping
xxxx	Burning
////	Stabbing
000	Numbness
ttttt	Tingling
ssss	Sensitive
pppp	Other

Pain Level (circle): Pain Free 1 2 3 4 5 6 7 8 9 10 Worst

How long have you had this pain? _____ Years ____ Months ____ Weeks ____ Days

First Episode of this Pain: Yes / No

How did it Happen?:_____

What makes it *Better*? □Nothing □Ice □Heat □Medication □Rest
□Chiropractic □Massage □Sleep □Movement □Other:_____

What makes it *Worse*? □Lifting □Bending □Twisting □Sitting □Standing
□Walking □Working □Moving □Other:_____

Does the Pain Travel?_____ Where?_____

Any other symptoms today?: □Dizziness □Nausea □Vomiting □Headache
□Vision Changes □Trouble Breathing□Trouble Swallowing
□Change in bathroom Habits □Other_____

Signature:_____ **Date:**_____

Review of Systems (In the last 5 years have you had?)

Musculoskeletal

□ No Musculoskeletal Complaints

□Osteoporosis □Back problems □Arthritis □Hip disorders □Scoliosis

□Knee injuries □Foot/ankle pain □Gout □Fractures □Poor posture

□Cramping □Shoulder problems□Neck pain □Elbow/wrist pain

□Swelling, redness deformity of joint(s) □Implants, plates, pins or screws

□Joint or muscle pains/stiffness □Cancer □OTHER

Neurological

□ No Neurological Complaints

□Anxiety and/or panic □Pins and needles □Depression □Numbness

□Memory issues □Loss of smell or taste □Sleeping issues □Headache

□Temporary loss of vision □Weak muscles □Difficulty concentrating

□Dizziness □Epilepsy or seizures □Stroke □OTHER

Head, Eyes, Ears, Nose and Throat

□No Complaints

□Headaches/Migraines □Dental problems □Eye or vision problems

□Gum problems □Eyeglasses or contact lenses □TMJ problems

□Eye surgery □Sore throat □Cataracts

□Postnasal drip □Glaucoma □Swollen lymph nodes

□Nose congestion or sinus trouble □Ear or hearing problems □OTHER

Cardiovascular

□No cardiovascular complaints

□Chest pain or tightness □Rheumatic fever □Palpitations □Heart murmur

□Leg pain upon walking □Swollen legs or feet □Blood clots □Excessive bruising

□High blood pressure □Varicose veins □Heart attack □Dizziness

□High cholesterol or triglycerides □Coronary artery disease □Low blood pressure

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Respiratory

□No respiratory complaints □Persistent cough □Blood in sputum

□Wheezing □Pneumonia □Shortness of breath □Snoring issues

□Asthma □Apnea □Emphysema □Tuberculosis □Hay fever □OTHER

Gastrointestinal

□No Complaints □Abdominal pain □Black or bloody stool □Heartburn

□Nausea or vomiting □Bloating □Hemorrhoids □Collitis □Severe diarrhea

□Food sensitivities □Ulcer □Constipation □Jaundice □Pancreatitis

□Difficulty swallowing □Irritable Bowel Syndrome □Liver disease □Gastric reflux

□Crohn's disease □Gallbladder problems □Colon cancer/colon polyps □Change in bowel habits

□OTHER

Genitourinary

□No genitourinary complaints □Painful or frequent urination □Sexual dysfunction

□Blood in urine □Incontinence □Kidney stones □Urinary infections □OTHER

Endocrine

□No endocrine complaints □Feeling hot or cold all the time □Hyperparathyroidism

□Thyroid problems □Testosterone deficiency □Diabetes □Cushing's syndrome

□Increase urination □Steroid treatments □Excessive thirst □Hyperthyroidism

□OTHER

Dermatological and Bleeding

□No skin or bleeding complaints □Skin trouble or rashes □Skin cancer □Flushing

□Easy bruising □Skin pigmentation issues □Change in hair or nails □Eczema

□Blood in stool □Excessive acne □Gum bleeding □Psoriasis □OTHER

Informed Consent

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Dear Patient:

While Chiropractic seeks to render the best and safest care, please understand that examination and treatment of any kind has limitations and risks. With respect to Chiropractic, these may include:

Stroke (CVA): current research indicates that this is a rare complication that can occur in spite of pre-treatment screening. To prevent problems, it is vitally important that you inform us of ANY and ALL history of stroke, ultrasound testing of arteries and results, and of ANY medical condition or changes of health status.

Inflammation/Bruises: these are more common side effects of manipulation and may involve pain, soreness, stiffness, or skin discoloration. Symptoms are usually self-resolving, but can necessitate referral to your medical provider for medications to alleviate the symptoms.

Fracture: this complication can occur when bone is weakened by osteoporosis, cancer, chemotherapy, or other conditions.

Skin irritation: due to taping, hot pack use and/or ultrasound and electrical muscle stimulation pads, these are usually self-resolving.

I, undersigned, have been fully informed by my Chiropractic Physician that there is no such thing as a perfect test or procedure in health care, or Chiropractic. I have been informed of all potential treatment complications, alternative treatments, and consequences of no treatment. I hereby grant Lisa N. Braden, D.C. to examine and treat me as necessary now and into the indefinite future.

_____

Patient (Print Name) Date Witness Signature Date

_____

Patient Signature

Blue Ribbon Chiropractic

Payment is due when the service is rendered.

Dr. Lisa N. Braden, D.C. is committed to the success of your chiropractic treatment and better health. Your clear understanding of our financial policy is important to our professional relationship. Blue Ribbon Chiropractic is not currently in network with any insurance plans and we do not bill to Medicare/Medicaid/TriCare. Our office currently accepts Personal Checks, VISA, MasterCard, and FSA/HSA, as well as Cash payment.

Cancellation Policy:

A 24-hour notice is required for cancelled appointments. An office visit charge of $45 will be applied to your account if any appointment is "no showed". If rescheduled prior to 24-hours of appointment, no charge will be applied to your account.

We understand that things come up and emergencies happen. However, because we block 20-30 minutes in the appointment schedule for you to meet with the doctor, this causes others with health care needs seeking treatment unable to come in when our schedule is full. As a courtesy, text message reminders are sent to remind you of your upcoming appointment. Due to the variation of cell phone plans the lack of delivery of a text reminder does not exclude you from paying the $45 fee if an appointment is missed.

I understand the above terms:

Printed Name: _____Date:_____

Signature: _____

Wittness:_____