



# CONFIDENTIAL PATIENT INFORMATION

## Clinic Use Only

\_\_\_ New                      W/C \_\_\_  
 \_\_\_ PPN                      Auto \_\_\_                      Dr: \_\_\_\_\_                      Xray# \_\_\_\_\_                      Chart# \_\_\_\_\_  
 \_\_\_ React                      Update \_\_\_                      Clinic: \_\_\_\_\_

## CPI Reviewed

Date & Initial: \_\_\_\_\_                      Date & Initial: \_\_\_\_\_                      Date & Initial: \_\_\_\_\_

## Patient Information

Last Name: \_\_\_\_\_                      First Name: \_\_\_\_\_                      M.I.: \_\_\_\_\_  
 Address: \_\_\_\_\_                      Apt/Unit #: \_\_\_\_\_  
 City: \_\_\_\_\_                      State: \_\_\_\_\_                      Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_                      Other Phone #: \_\_\_\_\_

Ok to leave a voicemail at the Primary Number.

Date of Birth: \_\_\_\_\_                      Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_                      **Marital:** S   M   D   W                      **Sex:** M   F  
 (VA Patients Required)

- IF PATIENT IS A MINOR:** Responsible Party's Name: \_\_\_\_\_  
 Responsible Party's DOB: \_\_\_\_\_                      Responsible Party's Phone #: \_\_\_\_\_  
 Responsible Party's Address (if different from above): \_\_\_\_\_

## Health Insurance Information

### Primary Insurance:

### Secondary Insurance:

Ins Name: _____	Ins Name: _____
Address: _____	Address: _____
State: _____                      Zip: _____	State: _____                      Zip: _____
<b>Subscriber's Name:</b> _____	<b>Subscriber's Name:</b> _____
<b>Subscriber's Birthdate:</b> _____	<b>Subscriber's Birthdate:</b> _____
<b>Policy ID#:</b> _____	<b>Policy ID#:</b> _____
<b>Group #:</b> _____	<b>Group #:</b> _____

## Emergency Contact Information

Spouse's Name: \_\_\_\_\_                      Other Contact Name: \_\_\_\_\_  
 Spouse's DOB: \_\_\_\_\_                      Relationship: \_\_\_\_\_  
 Primary Ph #: \_\_\_\_\_                      Primary Ph #: \_\_\_\_\_

## Release of Information

Authorized Person: \_\_\_\_\_                      Relationship to Patient: \_\_\_\_\_  
 Authorized Person: \_\_\_\_\_                      Relationship to Patient: \_\_\_\_\_  
 Authorization Expiration Date: \_\_\_\_\_

**Patient/ Guardian Signature:** \_\_\_\_\_                      **Date:** \_\_\_\_\_

# Health History Form

Patient Name: \_\_\_\_\_ Chart: \_\_\_\_\_

Ethnicity: Hispanic/ Non- Hispanic      Height: \_\_\_\_\_      Weight: \_\_\_\_\_      Gender: Male  Female

Do you have a Pacemaker or Heart Monitor?  Yes  No

**Females Only:** Are you pregnant?  Yes  No If Yes, expected due date: \_\_\_\_\_ OB Clinic Location: \_\_\_\_\_

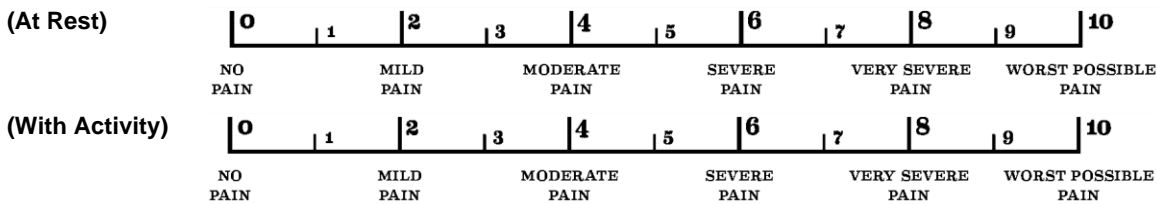
When did symptoms start and describe what happened : \_\_\_\_\_

Area of Injury: \_\_\_\_\_ Is this condition getting worse?  Yes  No

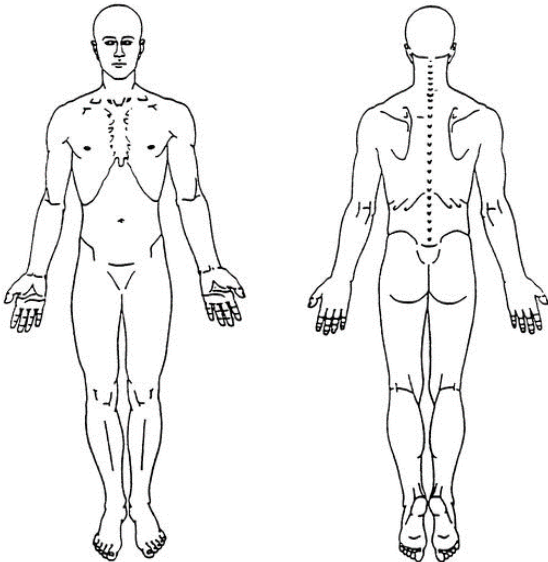
How often do you have this problem? \_\_\_\_\_ Is it constant  or does it come and go

Does it interfere with  Work  Sleep  Daily Routine  Recreation

**Mark your pain from 0 to 10 on the scale below**



Mark an "X" on the picture below where you have pain, numbness, stiffness, or tingling.



Please put a "✓" on the **Following Activities of Daily Living** that you have difficulty doing.

- |   |   |
|---|---|
| <input type="checkbox"/> Lying on Back/ Side/ Stomach | <input type="checkbox"/> Standing                   |
| <input type="checkbox"/> Lifting                      | <input type="checkbox"/> Bending Forward/ Backward  |
| <input type="checkbox"/> Kneeling                     | <input type="checkbox"/> Twist/Turn- LT/ RT         |
| <input type="checkbox"/> Looking Up/ Looking Down     | <input type="checkbox"/> Stooping/Squatting         |
| <input type="checkbox"/> Gripping                     | <input type="checkbox"/> Sleeping                   |
| <input type="checkbox"/> Sitting/Driving/Riding       | <input type="checkbox"/> Turning Over in Bed        |
| <input type="checkbox"/> Pushing/Pulling              | <input type="checkbox"/> Dressing Self/Bathing Self |
| <input type="checkbox"/> Get In/Out of Car            | <input type="checkbox"/> Using Computer             |
| <input type="checkbox"/> Walking                      | <input type="checkbox"/> Cough/Sneeze               |
| <input type="checkbox"/> Reaching                     | <input type="checkbox"/> Sexual Activity            |
| <input type="checkbox"/> Using Stairs                 | <input type="checkbox"/> Exercise                   |

Over the past 2 weeks, how often have you been bothered by any of the following?	Not At all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

**Total:** \_\_\_\_\_

**Medications**

- Blood Pressure     Diabetic Meds     Birth Control     Steroids     Muscle Relaxant     Antibiotics  
 Blood Thinner     Anti- Depressant     Anti- Anxiety     Pain Meds     Heart Meds     Cholesterol Meds

**Other/Vitamins/Herbs/Minerals/Supplements:** \_\_\_\_\_

(If you have a list of your medications, please present it to staff upon completion of this form.)

**Allergies**

Medications: \_\_\_\_\_

## Personal History

Have you received chiropractic care in the past?  Yes  No If yes, how long ago was your last treatment/ visit? \_\_\_\_\_

Name of your Primary Medical Doctor? \_\_\_\_\_ Date of last Physical Exam: \_\_\_\_\_

Are you currently under the care of a healthcare provider?  Yes  No If yes, for what condition(s) \_\_\_\_\_

## System Review Questions

Have you had any problems with the following areas **Now or In the Past?** (Place a "✓" next to the areas)

\_\_\_ Eyes (Glasses, Contacts, Floaters, Cataracts, Glaucoma, Etc.)

\_\_\_ Gastro-Intestinal (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc.)

\_\_\_ Ears, Mouth, Nose, Throat (Hearing Loss, Sinus, Etc.)

\_\_\_ Genito-Urinary (Male/Female Reproductive, Kidney, Bladder, Etc.)

\_\_\_ Cardiovascular (Heart, High BP, High Cholesterol, Etc.)

\_\_\_ Musculoskeletal (Breaks, Arthritis, Osteoporosis, Discs, Etc.)

\_\_\_ Respiratory (Lungs, Breathing, Asthma, COPD, Etc.)

\_\_\_ Skin (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc.)

\_\_\_ Neurological (Nerve Issues, Weakness, Numbness, Etc.)

\_\_\_ Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, Etc.)

\_\_\_ Endocrine (Thyroid, Hormonal Imbalances, Liver, Etc.)

\_\_\_ Others: \_\_\_\_\_

### Describe any major illnesses, injuries, falls, hospitalizations, accidents or surgeries:

Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Conditions: \_\_\_\_\_  Full Recovery  Complications

Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Conditions: \_\_\_\_\_  Full Recovery  Complications

### Have you ever: (Place a "✓" next to the areas)

Lost consciousness Date: \_\_\_\_\_  Been Treated for spine/nerve disorder Date: \_\_\_\_\_

Used a cane/crutch Date: \_\_\_\_\_  Had mental/emotional disorders Date: \_\_\_\_\_

## Family History

	Self	Mother	Father	Sister	Brother
<b>Cancer</b>					
<b>Rheumatoid Arthritis</b>					
<b>Diabetes</b>					
<b>Heart Disease</b>					
<b>High Blood Pressure</b>					
<b>High Cholesterol</b>					
<b>Osteoporosis</b>					
<b>Stroke</b>					
<b>Thyroid Disease</b>					
<b>Multiple Sclerosis</b>					

## Social History

**Work Activity:**  Sitting  Standing  Light Work  Heavy Work

**Diet/Nutrition:** Are you on any special diet?  Yes  No  
If yes, for what reason? \_\_\_\_\_

How many 8 oz glasses of water do you drink a day? \_\_\_\_\_

How many caffeine drinks do you drink a day? (soda, coffee, etc.)  
Cans \_\_\_\_\_ Cups \_\_\_\_\_ None \_\_\_\_\_

**Habits :** Tobacco Use (Smoking)  Now  Former  Never  
If now or former, how long? \_\_\_\_\_

Chewing Tobacco use:  Now  Former  Never

Alcohol Use:  Rare  Occasional  Regular  Never

Do you exercise:  Yes  No If yes, how long? \_\_\_\_\_

## Women's Section Only

### Check the following conditions you have/have had:

Painful Menstruation  Irregular Cycle  Lump(s) in Breast(s)  Menopausal Symptoms  Using Birth Control  Abnormal PAP

Date of last period: \_\_\_\_\_  No longer have Menstrual Cycle  Previous Miscarriage(s)

Are you pregnant?  Yes (If yes, Due Date) \_\_\_\_\_  No

**Signature of Patient/ Parent or Legal Guardian:** \_\_\_\_\_

# Consent Form

## INFORMED CONSENT

**The Nature of Chiropractic Treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” similar to the noise produced when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, cold laser therapy or traction may also be used.

**Possible Risks:** As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

**Probability of Risks Occurring:** The risks of complications due to chiropractic treatment have been described as “rare” to “extremely rare”, statistically less often than complications from taking a single aspirin tablet.

**Treatment Options other than Chiropractic Treatment:**

- **Medical Care:** Typically, anti-inflammatory drugs, muscle relaxers, or pain medications are recommended by medical doctors. Risks of these drugs include numerous undesirable side effects. There is also the possible risk of patient dependency on medication in some cases. Medical doctors may also consider physical therapy as an optional treatment plan.
- **Surgery:** Surgery, in conjunction with the above medical care, has the additional risk of adverse reaction to anesthesia and infection, often includes a prolonged convalescent period, and though rare, has included death.

**Risks of Remaining Untreated:** Delay in receiving treatment of spinal and other joint injuries may allow for formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce mobility and result in chronic pain. It is probable that delay in receiving treatment will complicate the condition and make future treatment of rehabilitation efforts more difficult.

**Patient’s Receipt of Informed Consent:** I have read the above explanation of chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

**Signature (Patient, Parent/ Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Patient Name (If patient is a minor):** \_\_\_\_\_

## INSURANCE CONSENT

I give permission for Bakke Chiropractic to give me medical treatment. I allow Bakke Chiropractic to file for insurance benefits to pay for the care I receive. I understand that Bakke Chiropractic will send my medical record information to my insurance company. I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.

- I authorize the release of any information Bakke Chiropractic deems appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred for services provided me by you or any member of your staff acting on your behalf.
- I authorize direct payment to Bakke Chiropractic of any sum I now or hereafter owe by any insurance company obligated to reimburse me for the charges for your services or by my attorney out of the proceeds of any settlement of my case.
- I understand that my insurance may not cover all, or any of the services that I will be receiving and that whatever amount you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.
- I understand that I am required to pay my co-pay or Patient Options charges at the time of my office visit.
- I am aware that Bakke Chiropractic does not bill insurance companies for massage services with the exception of pre-authorized injury cases, and that I am personally responsible for payment of these services at the time of visit.

**Signature (Patient, Parent/ Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

## AUTHORIZATION TO DISCLOSE INFORMATION

I, \_\_\_\_\_, hereby authorize Bake Chiropractic Clinic S.C. to release information related to my medical treatment and/ or financial account records to the following person(s):

\_\_\_\_\_  
(Name of Authorized)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Name of Authorized)

\_\_\_\_\_  
(Relationship to Patient)

### Expiration Date:

Unless otherwise revoked, this authorization will expire on the following date: \_\_\_\_\_

(I reserve the right to withdraw this authorization at any time by written, dated communication to Bakke Chiropractic Clinic S. C.)

I understand that if the authorization recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may then be disclosed by the recipient without obtaining any further authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**Signature (Patient, Parent/ Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

\* If this authorization is signed by a representative of the patient, please complete the following:

Representative Name: \_\_\_\_\_

Patient is: \_\_\_\_\_ Minor \_\_\_\_\_ Incompetent \_\_\_\_\_ Disabled \_\_\_\_\_

Deceased Legal Authority: \_\_\_\_\_ Parent of Minor \_\_\_\_\_ Legal Guardian Power of Attorney \_\_\_\_\_ Next of Kin \_\_\_\_\_

## WOMEN'S CONSENT FOR X-RAYS

### PREGNANCY WARNING AND CONSENT TO X-RAY

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 I may be pregnant the 10 days following onset of 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 of Bakke Chiropractic permission to perform an x-ray examination on me if they feel it is necessary.

I wish to decline to have X-Rays taken at this time

**Signature (Patient, Parent/Legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Acknowledgment for Consent to Use and Disclose Protected Health Information**

### **Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Bakke Chiropractic Clinic, S.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

### **Notice of Privacy Practices**

Paper copies of the Notice of Privacy Practices are available at the clinic's front desk and/or waiting area and should be reviewed carefully for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

### **Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**By my signature below I give permission to use and disclose my health information.**

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Patient/ Legal Guardian Signature

---

Date

---

Print Patient's Full Name

**Bakke Chiropractic Clinic**  
**Worker's Compensation History Form**

Name: \_\_\_\_\_ Date \_\_\_\_\_ Case# \_\_\_\_\_

Date of injury: \_\_\_\_\_ Approx. time of injury: \_\_\_\_\_  am  pm

Your occupation: \_\_\_\_\_

**Explain how the injury happened** (be specific) \_\_\_\_\_

\_\_\_\_\_

**Describe the environmental conditions** which may have contributed to your injury (darkness, faulty equipment, slippery floor, limited space, etc): \_\_\_\_\_

Did you seek any treatment prior to today as a result of the injury?  Yes  No

Please explain: \_\_\_\_\_

Were you taken off work or given any work restriction as a result of the injury?  Yes  No

Are you currently on any work restriction?  Yes  No Please explain: \_\_\_\_\_

Prior to this incident have you ever been injured /or had symptoms in the area now affected?  Yes  No

If yes, please explain (be specific) \_\_\_\_\_

Are your daily activities different since this injury?  Yes  No Please explain: \_\_\_\_\_

Have you contacted an Attorney?  Yes  No

**EMPLOYER COMPENSATION INFORMATION**

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Person to Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

**Did you report the injury:**  Yes  No If yes, reported to?: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Did you fill out a work injury report and turn it in?**  Yes  No

\*\*\*\*\*

<p><b>For Office Use Only</b></p> <p>Employer called: _____</p> <p>Has injury been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Work comp carrier? Carrier Address:</p> <p>Phone#: Claim # (assigned): Date of injury:</p>
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**My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_