BAKKE CHIROPRACTIC

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: _____
Subscriber's Name: _____	**Subscriber's Name:** _____
Subscriber's Birthdate: _____	**Subscriber's Birthdate:** _____
Policy ID#: _____	**Policy ID#:** _____
Group #: _____	**Group #:** _____

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 : _____

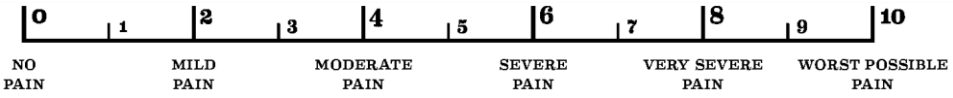
Area of Injury: _____ Is this condition getting worse? ☐ Yes ☐ No

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

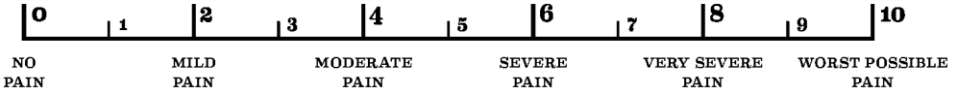
Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Mark your pain from 0 to 10 on the scale below

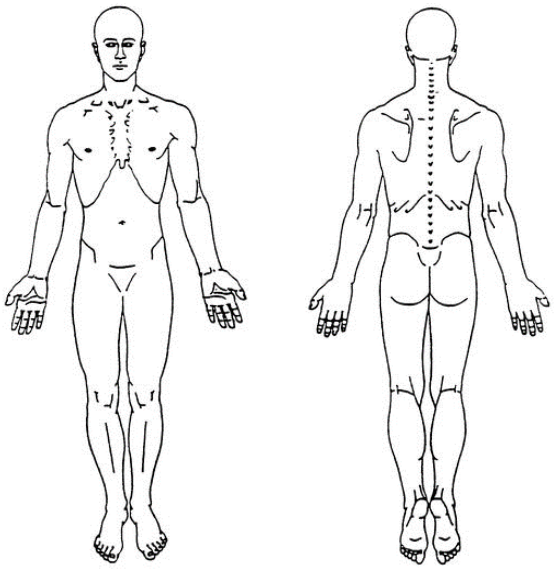
(At Rest)



(With Activity)



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.

___ Lying on Back/ Side/ Stomach	___ Standing
___ Lifting	___ Bending Forward/ Backward
___ Kneeling	___ Twist/Turn– LT/ RT
___ Looking Up/ Looking Down	___ Stooping/Squatting
___ Gripping	___ Sleeping
___ Sitting/Driving/Riding	___ Turning Over in Bed
___ Pushing/Pulling	___ Dressing Self/Bathing Self
___ Get In/Out of Car	___ Using Computer
___ Walking	___ Cough/Sneeze
___ Reaching	___ Sexual Activity
___ Using Stairs	___ 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.)

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

___ Cardiovascular (Heart, High BP, High Cholesterol, Etc.)

___ Respiratory (Lungs, Breathing, Asthma, COPD, Etc.)

___Neurological (Nerve Issues, Weakness, Numbness, Etc.)

___ Endocrine (Thyroid, Hormonal Imbalances, Liver, Etc.)

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

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

___ Musculoskeletal (Breaks, Arthritis, Osteoporosis, Discs, Etc.)

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

___ Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, 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
Cancer					
Rheumatoid Arthritis					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Osteoporosis					
Stroke					
Thyroid Disease					
Multiple Sclerosis					

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: _____

BAKKE CHIROPRACTIC

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:** _____

BAKKE CHIROPRACTIC

HIPAA AUTHORIZATION FORM

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 of 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.

_____ _____

Patient/ Legal Guardian Signature Date

_____

Print Patient's Full Name