GLACIER POINT
-Chiropractic Clinic-

PATIENT INFORMATION

Name: _____ Birth Date: _____/_____/_____ ○ Male ○ Female

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

Email Address: _____ Home Phone: _____

Mobile Phone: _____ Marital Status: _____ Social Security: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our office? _____

HISTORY OF COMPLAINTS

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and 0 being with pain, rate your above complaints by circling the number:

Primary Complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10
Secondary Complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10
Third Complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10
Fourth Complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10

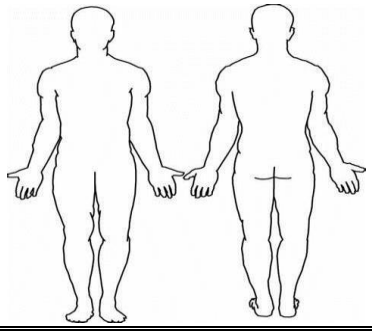
When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ MID-DAY ○ LATE PM
How long does it last? ○ Constant ○ On and Off throughout the day OR ○ Comes and Goes throughout the week.

How did the injury happen? _____

Condition(s) have ever been treated by anyone in the past? ○ NO ○ YES If yes, when: _____ by whom? _____

Name of Previous Chiropractor: _____ ○ N/A

PLEASE MARK the areas on the BODY with the following letters to describe your symptoms:
R= Radiating B= Burning D= Dull A=Aching N=Numbness S= Sharp/Stabbing T=Tingling



What relieves your symptoms? _____
What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:

Is your problem the result of ANY type of accident? ○ Yes ○ No

Identify any other injury(s) to your spine, minor, or major, that the doctor should know about:

_____

PAST HISTORY

Have you suffered with any of this or similar problems in the past? ◯No ◯Yes If yes, how many times? _____When was the last episode? _____How did the injury happen? _____

Other forms of treatment tried: No Yes If yes, please state what type of treatment: _____, and who provided it: _____How long ago? _____What were the results _____
Please Explain: _____

Please identify any and all types of jobs you had in the past that imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for Past, C for Currently Have or N for Never Had:

____Broken Bone _____Dislocations _____Tumors ____Rheumatoid Arthritis ____Disability ____Cancer ____Heart Attack
____Osteo Arthritis _____Diabetes ____Cerebral Vascular _____Other Serious Conditions: _____

PLEASE identify ALL PAST and any Current conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHO,
INJURIES:			
SURGERIES:			
CHILDHOOD DISEASES:			
ADULT DISEASES:			

SOCIAL HISTORY

1.Smoking: __Cigars __Pipe ___Cigarettes How often? ◯ Daily ◯Weekends ◯Occasionally ◯ Never
2.Alcoholic Beverage: Consumption Occurs ◯ Daily ◯Weekends ◯Occasionally ◯ Never
3. Recreational Drug Use: ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never
4. Hobbies-Recreational Activities-Exercise Regiment: How does your present problem affect….(Please see Activities of Daily Form)

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ◯ No ◯ Yes
   If yes, whom: _____
   Have they ever been treated for their condition? ◯ No ◯Yes ◯ I don't know
2. Any other hereditary conditions the doctor should be aware of? ◯ No ◯ Yes: _____

_____ _____

Patient or Authorized Person's Signature Date Completed

_____ _____

Provider's Signature Date Completed

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstance under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances:

1. Treatment purposes- discussion with other healthcare providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes- to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety- to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement- to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoners, and government benefits purposes.
9. Deceased persons- discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders- we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners will have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when time notice is provided (72 hours). X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Printed Patient's Name	Signature	Date
_____	_____	_____
Printed Guardian's Name (if patient is minor)	Signature	Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold or hot packs, electric muscle stimulation, mechanical traction, therapeutic exercises, or therapeutic ultrasound may be used.

Possible risk: As with any health care procedures, complications are possible following chiropractic manipulation. Complications could include bone fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. 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 minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks:

I have read the explanation above of chiropractic treatment. I have taken the opportunity to have any questions answered to my satisfaction. I have fully 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.

_____	_____	_____
Printed Patient's Name	Signature	Date
_____	_____	_____
Printed Guardian's Name (if patient is minor)	Signature	Date

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

Carry Children/ Groceries	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Lift Children/ Groceries	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Yard Work	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (Limits)	○ Unable to Perform
Other:	○ No Effect	○ Painful (Limits)	○ Unable to Perform

_____

_____

REVIEW OF SYSTEMS

Please mark P for Past C for Currently Have N for Never

___Headache	___Dizziness	___Ulcers
___Neck Pain	___Loss of Balance	___Heart Burn
___Jaw Pain, TMJ	___Fainting	___Heart Problems
___Shoulder Pain	___Double Vision	___High Blood Pressure
___Upper Back Pain	___Blurred Vision	___Low Blood Pressure
___Mid Back Pain	___Ringing in Ears	___Asthma
___Low Back Pain	___Hearing Loss	___Difficulty Breathing
___Hip Pain	___Depression	___Lung Problems
___Back Curvature	___Irritable	___Kidney Trouble
___Scoliosis	___Mood Changes	___Gall Bladder Problems
___Numb/Tingling Arms, Hands, Fingers	___ADHD	___Liver Trouble
___Numb/Tingling Legs, Feet, Toes	___Allergies	___Hepatitis

___Currently Pregnant	___Prostate Problems	___Frequent Colds/ Flu
___Impotence/ Sexual Dysfunction	___Convulsion/ Epilepsy	___Digestive Problems
___Tremors	___Colon Troubles	___Chest Pain
___Diarrhea/Constipation	___Pain with Cough/Sneeze	___Menstrual Problems
___Foot or Knee Problems	___PMS	___Sinus/Drainage Problems
___Bed Wetting	___Swollen, Painful Joints	___Learning Disability
___Skin Problems	___Eating Disorder	___Trouble Sleeping

PAIN SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No Pain _____ Worst Pain Possible

0 1 (2) 3 4 (5) 6 7 (8) 9 10

1- What is your pain RIGHT NOW?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2- What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3- What is your pain AT ITS BEST (How close to "0" does your pain get at its BEST)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4- What is your pain level AT ITS WORST (How close to "10" does your pain get at its WORST)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____