



ABBOTT FAMILY
CHIROPRACTIC

1620 S. Lawe St. Suite 2, Appleton, WI 54915
920-243-7140

Legal name: _____ Prefer to be called: _____

Date of birth: ____ / ____ / ____ Age: ____ M/F: ____ Occupation: _____

Home address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ E-mail address: _____

In case of an emergency, please notify: _____ Phone: _____

Interested in appointment reminders? If yes, do you prefer ____ Email ____ Text

(Either option will be sent to you 2 hours prior to each appointment)

If text messages are preferred, which company provides your cell phone service: _____

Marital status: *Single Married Divorced Widowed Partnered* Name of spouse: _____

Names and ages of children: _____

How did you hear about us? _____ Have you previously been to a chiropractor? Yes No

PLEASE READ: The purpose of today's visit is to see if chiropractic can help you.

The fee for today's consultation is \$129 (unless special arrangements have been previously discussed) and will be due today. If we feel chiropractic may help you and you choose to be adjusted today, the fee will be \$35.

PLEASE INITIAL HERE indicating that you have read and understand this section: _____

Women (if pregnant):

How many weeks along are you? _____ Estimated Due Date: _____

How many times have you been pregnant? _____ Who is your OB/midwife? _____

What are your plans for birth? *Natural Vaginal with epidural Cesarean*

Planned location? *Home Birthing Center Hospital*

Have you had any ultrasounds? Yes No How many? _____

Health concerns for you or baby? _____

Reasons for visiting our office today:

No complaints, I'm here to use chiropractic care for my overall well-being.

1. _____ For how long? _____

How did it start? *Gradual Incident:* _____

Severity (0-10)? _____ What words would you use to describe it? _____

What makes it better? _____ What makes it worse? _____

What percentage of the day do you experience it? _____ Other providers you have seen for this? _____

2. _____ For how long? _____

How did it start? *Gradual Incident:* _____

Severity (0-10)? _____ What words would you use to describe it? _____

What makes it better? _____ What makes it worse? _____

What percentage of the day do you experience it? _____ Other providers you have seen for this? _____

3. _____ For how long? _____

How did it start? *Gradual Incident:* _____

Severity (0-10)? _____ What words would you use to describe it? _____

What makes it better? _____ What makes it worse? _____

What percentage of the day do you experience it? _____ Other providers you have seen for this? _____

Physical history:

Broken bones or major injuries: _____
Accidents or major trauma: _____
Sports throughout life: _____
Surgeries: _____

Chemical history:

Medications: _____
Current medication/vaccination: _____
Tobacco / alcohol / other drug use: _____
Nutritional supplements: _____

Emotional history

Stress level (0-10): _____ Job satisfaction (0-10): _____
Personal fulfillment (0-10): _____ Professional development(0-10): _____

Current and past body signals indicating underlying dysfunction: (Circle)(Check)

- | | | | |
|----------------------------|------------------------|--|--------------------|
| Abdominal pain | Diabetes Type 1 2 | Menstrual irregularity | Persistent cough |
| ADHD | Disc herniation | Menstrual pain | Pubic symphysis |
| Allergies | Difficulty swallowing | Moody/irritable | dysfunction |
| Amenorrhea | Digestion difficulties | Multiple Sclerosis | Rash/redness |
| Anxiety | Double vision | Nausea | Rib pain |
| Asthma | Ear infections | Neck pain | Ringing in ears |
| Autoimmune disease | Excess stress | Numbness/tingling | Sexual dysfunction |
| Back pain | Excessive sweating | Pain with coughing,
sneezing, straining | Seizures |
| Bedwetting | Fatigue | Pain: | Sinus problems |
| Blood disorder | Fainting | Shoulder | Sleep difficulties |
| Behavioral issues | Fibromyalgia | Elbow | Falling asleep |
| Breastfeeding difficulties | Frequent colds/flu | Wrist | Staying asleep |
| Blurry vision | Headaches | Hand | Slurred speech |
| Cancer | Heartburn | Hip | Tailbone pain |
| Chest pain | High blood pressure | Knee | Torticollis |
| Confusion | Incontinence | Ankle | Weakness |
| Constipation | Infertility | Foot | Vision changes |
| Colic | Jaw pain/TMJ | | Vomiting |
| Depression | Jaundice | | |

How is your daily life (work, family, social) disrupted by your health? How does your health get in the way of your quality of life?

Goals: What would you like to be able to do if your health was not a limiting factor?

I consent to a professional chiropractic evaluation examination deemed necessary by the doctor. I understand that any fee for services rendered is due at the time of service.

Signature: _____ Date: _____

Abbott Family Chiropractic, S.C.
INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but in this office instruments will be primarily utilized. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic care may include soreness or bruising. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidences 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 the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative options have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE ABBOTT FAMILY CHIROPRACTIC, S.C. TO PROCEED WITH CHIROPRACTIC CARE.

DATED THIS _____ DAY OF _____, 20____

Patient Signature

Doctor Signature

Date

Abbott Family Chiropractic, S.C.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization:**

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

