Welcome

PLEASE TAKE A FEW MOMENTS TO COMPLETE THIS FORM SO THAT WE CAN BETTER SERVE YOU. IF YOU HAVE ANY QUESTIONS ALONG THE WAY PLEASE DO NOT HESITATE TO ASK. THANK YOU.

Carson Chiropractic

community • family • health • strength • natural • prevention • balance

DATE: _____

PATIENT INFORMATION

_____

NAME: LAST FIRST M.I.

_____

CALLED NAME SUFFIX

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ ❑ MALE ❑ FEMALE

❑ MINOR ❑ SINGLE ❑ MARRIED ❑ PARTNERED
❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PRIMARY PHONE: _____ ❑ CELL ❑ HOME

SECONDARY PHONE: _____ ❑ CELL ❑ HOME

E-MAIL: _____

OCCUPATION: _____

EMPLOYER: _____

RACE/ETHNICITY:

❑ AMERICAN INDIAN
❑ ALASKA NATIVE
❑ ASIAN
❑ BLACK/AFRICAN AMERICAN
❑ NATIVE HAWAIIAN
❑ OTHER/PACIFIC ISLANDER
❑ WHITE
❑ DECLINED TO STATE

ARE YOU HISPANIC OR LATINO: ❑ YES ❑ NO ❑ DECLINE TO STATE

PRIMARY LANGUAGE: _____

WHO MAY WE THANK FOR REFERRING YOU?

_____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE: _____

MANUAL THERAPY/MASSAGE CANCELLATION POLICY

I understand that if I am unable to make my scheduled manual therapy/massage appointment, that **24 HOUR NOTICE IS REQUIRED.** Failure to show for a scheduled appointment will result in a **$25 FEE** for each half hour missed, billed directly to me, the patient. I accept that I am personally responsible, and not insurance, for this cancellation fee.

SIGNATURE: _____

FINANCIAL RESPONSIBILITY

❑ **NON-INSURANCE PATIENT:** I understand that I am financially responsible for all charges incurred at **CARSON CHIROPRACTIC**, including, but not limited to, treatment cost, x-rays, products and/or other services. My account balance is to be paid in full at time of service, unless other financial arrangements have been made with the billing department.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN. DATE

_____

PRINT PATIENT'S NAME RELATIONSHIP TO PATIENT

❑**INSURANCE PATIENT**: (PLEASE MARK ONE)
❑ MAJOR MEDICAL ❑MEDICARE ❑MEDICAID

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), assign directly to **Carson Chiropractic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand my financial responsibility for all charges, whether or not paid by insurance including, but not limited to, deductible, co-pay, co-insurance, x-rays, and products or services not covered by my insurance policy. I authorize **Carson Chiropractic** to disclose any health care information to my insurance company for the purpose of obtaining payment for services and determining insurance benefits, and I agree to pay all balances due in a timely manner.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN. DATE

_____

PRINT PATIENT'S NAME RELATIONSHIP TO PATIENT

ACCIDENT PATIENT: Is condition the result of an automobile accident, personal injury or work accident?
❑ No ❑Yes, Auto/Personal Injury ❑Yes, Workers Compensation

X-RAY POLICY

If deemed necessary by both patient and doctor, x-rays **may** be taken in the office.

I understand that in order to provide me with the best quality of care, it is **CARSON CHIROPRACTIC'S** policy to have any x-rays taken in the office interpreted by the board certified radiologists at **GREGERSON RADIOLOGY CONSULTS.**

I accept that I am responsible for any additional fees charged for x-ray readings. I release any medical information pertaining to my condition for billing purposes. I understand that **I** and/or **MY INSURANCE**, if applicable, may be billed directly by **GREGERSON RADIOLOGY CONSULTS** for their services and that I am responsible for any remaining balance.

SIGNATURE: _____

I authorize **CARSON CHIROPRACTIC** to request any/all medical records related to my condition from other health care providers who have treated me.

PRINT NAME: _____ SIGNATURE: _____

Office Use Only

❑ ***Welcome Form/Consent/HIPPA completed and signed***
❑ ***PI or WC Accounts:*** *intake form completed*
❑ ***EHR:*** *entered in EZ BIS*
❑ ***Medicare:*** *ABN form signed*
❑ ***General Information:*** *entered into EZ Bis (INCLUDING PHONE #)*
❑ ***Insurance:*** *Entered into EZ BIS and noted on travel card*

NAME:

PATIENT RECORD OF DISCLOSURE

THE **HIPAA** PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND PROVIDES THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS BE MADE BY ALTERNATIVE MEANS INDICATED BY YOU, THE PATIENT. A DETAILED COPY OF THE HIPAA PRIVACY NOTICE CAN BE MADE AVAILABLE TO YOU UPON YOUR REQUEST.

PLEASE INDICATE BELOW HOW YOU WISH TO BE CONTACTED (PLEASE CHECK ALL THAT APPLY) AND SIGN BELOW:

MOBILE NUMBER: ( ) _____
- ❑ OKAY TO LEAVE DETAILED MESSAGE
- ❑ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY
- ❑ OKAY TO TEXT MESSAGE

HOME NUMBER ( ) _____
- ❑ OKAY TO LEAVE DETAILED MESSAGE
- ❑ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WORK NUMBER: ( ) _____
- ❑ OKAY TO LEAVE DETAILED MESSAGE
- ❑ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WRITTEN COMMUNICATION
- ❑ OKAY TO MAIL TO MY HOME ADDRESS _____

SIGNATURE: _____

MEDICAL INFORMATION

PRIMARY CARE PROVIDER: _____

WHAT TREATMENTS HAVE YOU RECEIVED FOR CURRENT CONDITION?

❑ NONE ❑ CHIROPRACTIC SERVICES ❑ PHYSICAL THERAPY

❑ MEDICATION: _____

❑ SURGERY: _____

OTHER: _____

WHAT TREATMENTS, IF ANY, DID YOU FIND HELPFUL AND/OR WHAT TREATMENTS HAVE AGGRAVATED YOUR CONDITION?

DATE OF LAST:

PHYSICAL: _____ SPINAL EXAM: _____

CHEST X-RAY: _____ SPINAL X-RAY: _____

MRI, CT-SCAN, BONE SCAN: _____

NAME, ADDRESS, PHONE AND FAX OF ANY DOCTOR(S) WHO HAVE TREATED YOUR CONDITION:

MEDICATIONS AND DOSAGES

VITAMINS/SUPPLEMENTS

ALLERGIES

WORK ACTIVITY

❑ SITTING ❑ STANDING ❑ LIGHT LABOR ❑ HEAVY LABOR

BRIEFLY DESCRIBE WORK ACTIVITY: _____

INJURIES AND SURGERIES

(DATE AND DESCRIPTION)

FALLS: _____

HEAD INJURIES: _____

BROKEN BONES/FRACTURES/DISLOCATIONS: _____

SURGERIES: _____

FAMILY HEALTH HISTORY

(NOTATE SPECIFIC TYPE AND RELATION)

ARTHRITIS: _____

CANCER: _____

DIABETES: _____

HEART DISEASE: _____

OTHER: _____

HABITS

- ❑ SMOKING — PACKS/DAY: _____
- ❑ FORMER SMOKER — WHEN DID YOU QUIT: _____
- ❑ ALCOHOL — DRINKS/WEEK: _____
- ❑ COFFEE/CAFFEINE — CUPS/DAY: _____
- ❑ HIGH STRESS LEVEL — REASON: _____
- ❑ OTHER: _____ — FREQUENCY: _____

EXERCISE

❑ NONE ❑ MODERATE ❑ HEAVY ❑ DAILY

TYPE OF EXERCISE: _____

NAME:

HEALTH HISTORY

IF YES, PLEASE NOTATE DATES AND TREATMENTS

ADD/ADHD:	❑YES	❑NO	HYPERTENSION/HIGH BLOOD PRESSURE:	❑YES	❑NO
AIDS/HIV:	❑YES	❑NO	KIDNEY DISEASE:	❑YES	❑NO
ALCOHOLISM:	❑YES	❑NO	LIVER DISEASE:	❑YES	❑NO
ALLERGY SHOTS:	❑YES	❑NO	MIGRAINE HEADACHES:	❑YES	❑NO
ANEMIA:	❑YES	❑NO	MISCARRIAGE:	❑YES	❑NO
APPENDICITIS:	❑YES	❑NO	MONONUCLEOSIS	❑YES	❑NO
ARTHRITIS:	❑YES	❑NO	MULTIPLE SCLEROSIS:	❑YES	❑NO
ASTHMA:	❑YES	❑NO	OSTEOPOROSIS:	❑YES	❑NO
BI-POLAR DISORDER:	❑YES	❑NO	PACEMAKER:	❑YES	❑NO
BLEEDING DISORDER:	❑YES	❑NO	PARKINSON'S DISEASE:	❑YES	❑NO
BREAST LUMP:	❑YES	❑NO	PINCHED NERVE:	❑YES	❑NO
BRONCHITIS:	❑YES	❑NO	PNEUMONIA:	❑YES	❑NO
CANCER:	❑YES	❑NO	PROSTATE PROBLEMS:	❑YES	❑NO
CATARACTS:	❑YES	❑NO	PROSTHESIS:	❑YES	❑NO
CHEMICAL DEPENDENCY:	❑YES	❑NO	PSYCHIATRIC CARE:	❑YES	❑NO
CHICKEN POX:	❑YES	❑NO	RHEUMATOID ARTHRITIS:	❑YES	❑NO
DEPRESSION:	❑YES	❑NO	SCOLIOSIS:	❑YES	❑NO
DIABETES:	❑YES	❑NO	SHINGLES:	❑YES	❑NO
EATING DISORDER:	❑YES	❑NO	STROKE:	❑YES	❑NO
EMPHYSEMA:	❑YES	❑NO	SUICIDE ATTEMPT:	❑YES	❑NO
EPILEPSY:	❑YES	❑NO	THYROID PROBLEMS:	❑YES	❑NO
GLAUCOMA:	❑YES	❑NO	ULCERS:	❑YES	❑NO
GOUT:	❑YES	❑NO	VD/STD:	❑YES	❑NO
HEART DISEASE:	❑YES	❑NO			
HEPATITIS:	❑YES	❑NO			
HERNIA:	❑YES	❑NO			
HERNIATED DISC:	❑YES	❑NO			
HIGH CHOLESTEROL:	❑YES	❑NO			

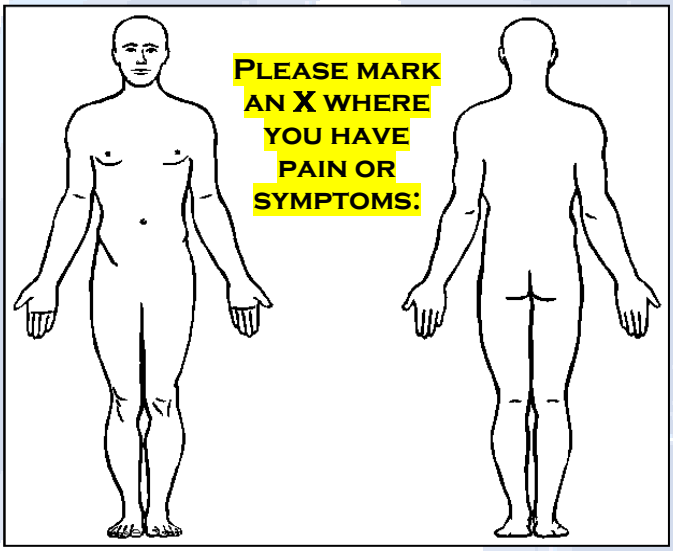
OTHER: _____

TREATMENTS: _____

_____

ARE YOU PREGNANT? _____ ❑YES ❑NO

WEEKS PREGNANT: _____ DUE DATE: _____



MARK IF YOU EXPERIENCE ANY OF THE FOLLOWING:

Fatigue ❑YES ❑NO Irritability/Mood Swings ❑YES ❑NO

Poor Digestion ❑YES ❑NO Difficulty Sleeping ❑YES ❑NO

PATIENT CONDITION

PRIMARY REASON FOR VISIT: _____

_____

_____

_____

WHEN DID SYMPTOMS FIRST APPEAR? _____

_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ❑ YES ❑ NO

CONDITION RATE ONLY THE AREAS BRINGING YOU IN FOR CARE	RATE PAIN 0-10, 0=NO PAIN, 10=SEVERE PAIN	Sharp	Dull	Throbbing	Numbnes	Tightness	Shooting	Burning	Tingling	Cramping	Aching	Stiffness	Swelling	Is the pain constant or comes & goes?
PAIN/TENSION: NECK														
PAIN/TENSION: MID/UPPER BACK														
PAIN/TENSION: LOW BACK														
EXTREMITIES: _____														
HEADACHES														
OTHER: _____														

Patient Name: _____

INFORMED CONSENT

Carson Chiropractic
4541 Route 71-Oswego, IL 60543
(630) 551-1003

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to one or all of the following procedures:

Spinal manipulative therapy	Radiographic Studies	Concussion assessment	Vital Signs
Range of motion testing	Orthopedic testing	Basic neurological testing	Palpation
Muscle strength testing	Hot/Cold Therapy	Ultrasound	Active Release Technique®
Kinesiology Taping	Exercise instruction	Home exercise plan	Postural analysis
EMS (electric stimulation)	Manual Muscle Soft-Tissue work (instrument or hands-on)		
Other: _____			

The material risks inherent in spinal manipulative therapy (chiropractic adjustment) and other treatments at this clinic:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. With any muscle therapy there is the possibility of soreness felt the same or next day. With instrument-assisted massage and ART®, there is the possibility of bruising or redness in the worked area. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we will check for during the taking of your history, examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options for your condition may include:

- Over-the-counter analgesics (self-administered) and rest
- Physical Therapy
- Surgery
- Hospitalization
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to Treat Minor (if applicable): I hereby request and authorize Dr. Carson and/or Dr. Hosten to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select an authorize health care services for the minor child name above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will notify this office immediately.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation for the chiropractic adjustment and related treatment. I have discussed with _____ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that evaluation and treatment.

_____ _____
Print Patient's Name Date Signature of Patient/Parent or Guardian (if minor) Date

_____ _____
Doctor (Print) Doctor's Signature